

# DELAWARE STATE MEDICAL JOURNAL

**Official Organ of the Medical Society of Delaware**

INCORPORATED 1789

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VOLUME 30

DECEMBER, 1958

NUMBER 12

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## PROCEEDINGS OF THE HOUSE OF DELEGATES

Complete Contents on Page iv



Stop useless nagging cough

## HISTADYL E.C.

(Thenylpyramine Compound E.C., Lilly)

Effective, pleasantly flavored antitussive

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AGAINST  
THE  
UBIQUITOUS  
HOSPITAL  
STAPHYLOCOCCUS

# CHLOROMYCETIN®

Staphylococci are notorious for the variety of infections they cause and for their ability to develop resistance to certain antibiotics.<sup>1-3</sup> According to recent *in vitro* studies, however, these stubborn pathogens remain sensitive to CHLOROMYCETIN.<sup>3-8</sup>

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CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

**REFERENCES:** (1) Wise, R. I.: *J.A.M.A.* 166:1178, 1958. (2) Brown, J. W.: *J.A.M.A.* 166:1185, 1958. (3) Caswell, H. T., et al.: *Surg., Gynec. & Obst.* 106:1, 1958. (4) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (5) Waibren, B. A.: *Wisconsin M. J.* 57:89, 1958. (6) Royer, A., in Welch, H., & Marti-Ibañez, E.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 783. (7) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (8) Blair, J. E., & Carr, M.: *J.A.M.A.* 166:1192, 1958. (9) Horan, J. M.: *Pediatrics* 19:36, 1957. (10) Rawls, G. H.: *Am. Surgeon* 23:1030, 1957. (11) Sarason, E. L., & Bauman, S.: *Surg., Gynec. & Obst.* 105:224, 1957. (12) James, U.: *Brit. J. Clin. Pract.* 11:801, 1957. (13) Turnbull, R. B., Jr.: *J.A.M.A.* 164:756, 1957. (14) Ross, S.; Puig, J. R., & Zaremba, E. A., in Welch, H., & Marti-Ibañez, E.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 803. (15) Leachman, R., & Yow, E. M., in Conn, H. F.: *Current Therapy 1958*, W. B. Saunders Company, Philadelphia, 1958, p. 51.

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\*Adapted from Godfrey & Smith.<sup>1</sup> Staphylococci studied were strains isolated from 28 patients in a general hospital.

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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.

(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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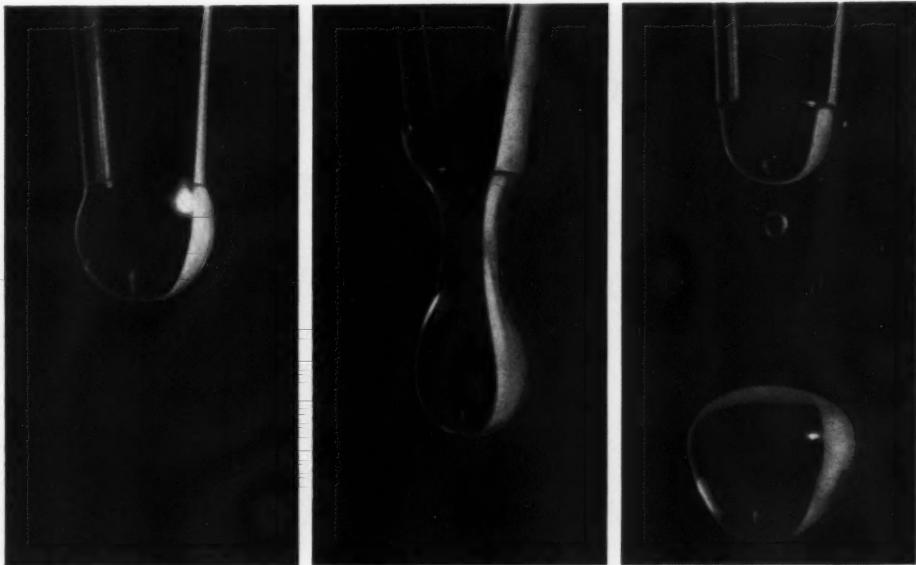
<sup>1</sup> Friedlander, H. S.: *The role of ataractics in cardiology.* Am. J. Card. 1:395, March 1958.

<sup>2</sup> Shapiro, S.: *Observations on the use of meprobamate in cardiovascular disorders.* Angiology 8:504, Dec. 1957.

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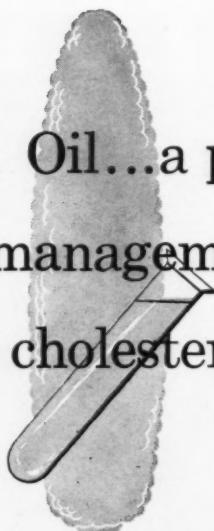
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For a 3000 calorie diet	2.5 tablespoonsful
For a 2000 calorie diet	1.5 tablespoonsful

\*Reg. U. S. Pat. Off.

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the first "wide range" antihypertensive

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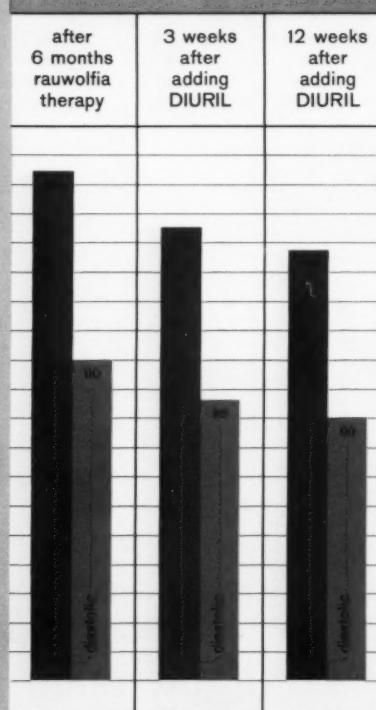
a logical alliance of two antihypertensives  
you know and trust provides  
**increased effectiveness, decreased side effects**

**potentiated effect**

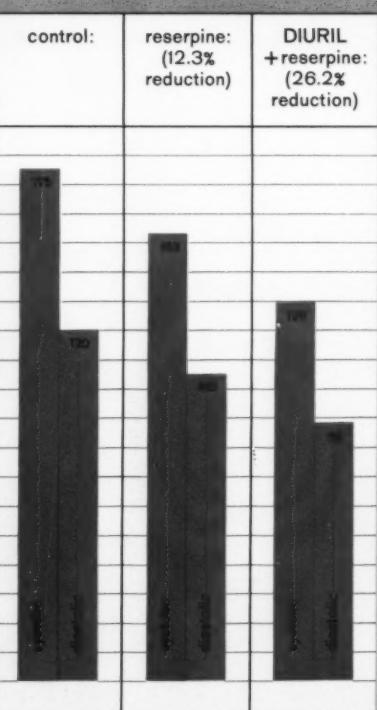
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Average antihypertensive effect  
of rauwolfa and rauwolfa+DIURIL  
in 25 patients<sup>1</sup>



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of reserpine and DIURIL+reserpine  
in 7 patients<sup>2</sup>



# DIUPRES

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## effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

## provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

## rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

## fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

## often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).<sup>1,4</sup>

## virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, par-

ticularly rauwolfa<sup>5</sup> and hydralazine,<sup>6</sup> may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.<sup>6</sup>)

## diet more palatable

With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

*"It may well be that the drug [DIURIL] produces the benefits of a markedly restricted low sodium diet but without its hardships."<sup>3</sup>*

## subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

## convenient, controlled dosage

Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

*"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet, provided this gives approximately the correct dosage of each."<sup>6</sup>*

## economical

DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

**Indications:**

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

**Precautions:**

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

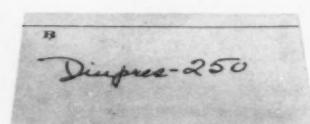
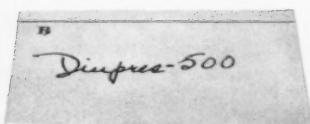
**Recommended dosage range:**

DIUPRES-500—one tablet one to three times a day.

DIUPRES-250—one tablet one to four times a day.

If necessary, other agents may be added.

If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



## DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.  
Bottles of 100, 1000.

## DIUPRES-250

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# If you were to examine these patients



could you  
detect  
the asthmatic on  
**Medrol**?

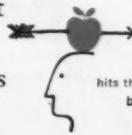
Probably not. Not without a history.

First, because he's more than likely symptom-free.

Second, because he shows none of the disturbing changes in appearance, behavior or metabolism sometimes associated with corticotherapy.

Even your practiced clinical eye would find it difficult to spot someone else's Medrol patient.

But in your own patients, you could see the advantages of Medrol right away. Why not try it?



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but spares the  
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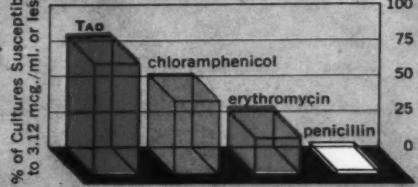
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**CLINICAL  
RESULTS**

	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

**Types of infecting organisms:** The majority of identified etiologic microorganisms were *Staph. aureus* and *Staph. albus*. Tao has its greatest usefulness against organisms such as: *staphylococci* (including strains resistant to other antibiotics), *streptococci* (*beta-hemolytic* strains, *alpha-hemolytic* strains and *enterococci*), *pneumococci*, *gonococci*, *Hemophilus influenzae*.

**Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to Tao, erythromycin, penicillin and chloramphenicol.**



Antibiotic	% of Cultures Susceptible
Tao	85
chloramphenicol	65
erythromycin	45
penicillin	15

**REACTIONS:**

(a) adults

- Total—9.2%  
(20 out of 217)
- Skin rash—1.4%  
(3 out of 217)
- Gastrointestinal—  
7.8% (17 out of 217)

(b) children

- Total—0.6%  
(1 out of 167)
- Skin rash—none
- Gastrointestinal—  
0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

**stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation.**

**Dosage and Administration:** Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since Tao is therapeutically stable in gastric acid, it may be administered at any time, without regard to meals.

**Supplied:** Tao Capsules—250 mg. and 125 mg.; bottles of 60, (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

**References:** 1. English, A. R., and Fink, F. C.: *Antibiotics & Chemother.* (Aug.) 1958. 2. English, A. R., and McBride, T. J.: *Antibiotics & Chemother.* (Aug.) 1958. 3. Wennersten, J. R.: *Antibiotic Med. & Clin. Therapy* (Aug.) 1958. 4. Celmer, W. D., et al.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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ELECTIVE AND TRAUMATIC

*use XYLOCAINE first...  
as a local anesthetic  
or a topical anesthetic*

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SPRAY

INFILTRATION

NERVE BLOCK



Xylocaine HCl solution, the versatile anesthetic for general office surgery, relieves pain promptly and effectively with adequate duration of anesthesia. It is safe and predictable. Local tissue reactions and systemic side effects are rare. Supplied in 20 cc. and 50 cc. vials; 0.5%, 1% and 2% without epinephrine and with epinephrine 1:100,000; also in 2 cc. ampules; 2% without epinephrine and with epinephrine 1:100,000.

**XYLOCAINE® HCl SOLUTION**

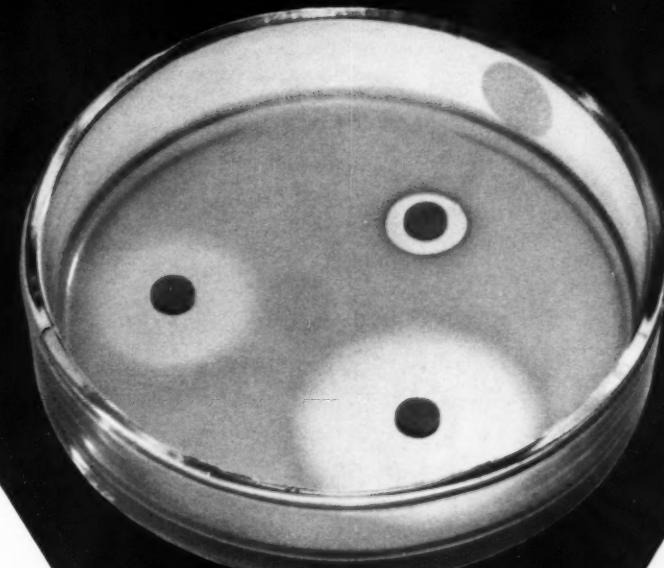
(brand of lidocaine\*)



Astra Pharmaceutical Products, Inc., Worcester 6, Mass., U.S.A.



\*U.S. PAT. NO. 2,441,498      MADE IN U.S.A.

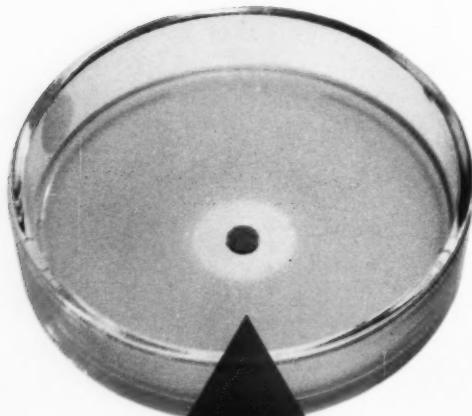


*for  
the control  
of all  
coccal  
infections*

# abbott's antibiotic triad

# Erythroc<sup>®</sup>in stearate

(Erythromycin Stearate, Abbott)



against  
staph-, strep-  
and  
pneumococci

#### *indications:*

In infections caused by staphylococci, streptococci (including enterococci) and pneumococci. Also, against organisms that have become resistant to other antibiotics. ERYTHROCIN should be used where patients are allergic to penicillin or other antibacterials.

#### *dosage:*

Usual adult dose is 250 mg. every six hours; for severe infections, usual dose is 500 mg. every six hours. Child's dose may be reduced in proportion to body weight.

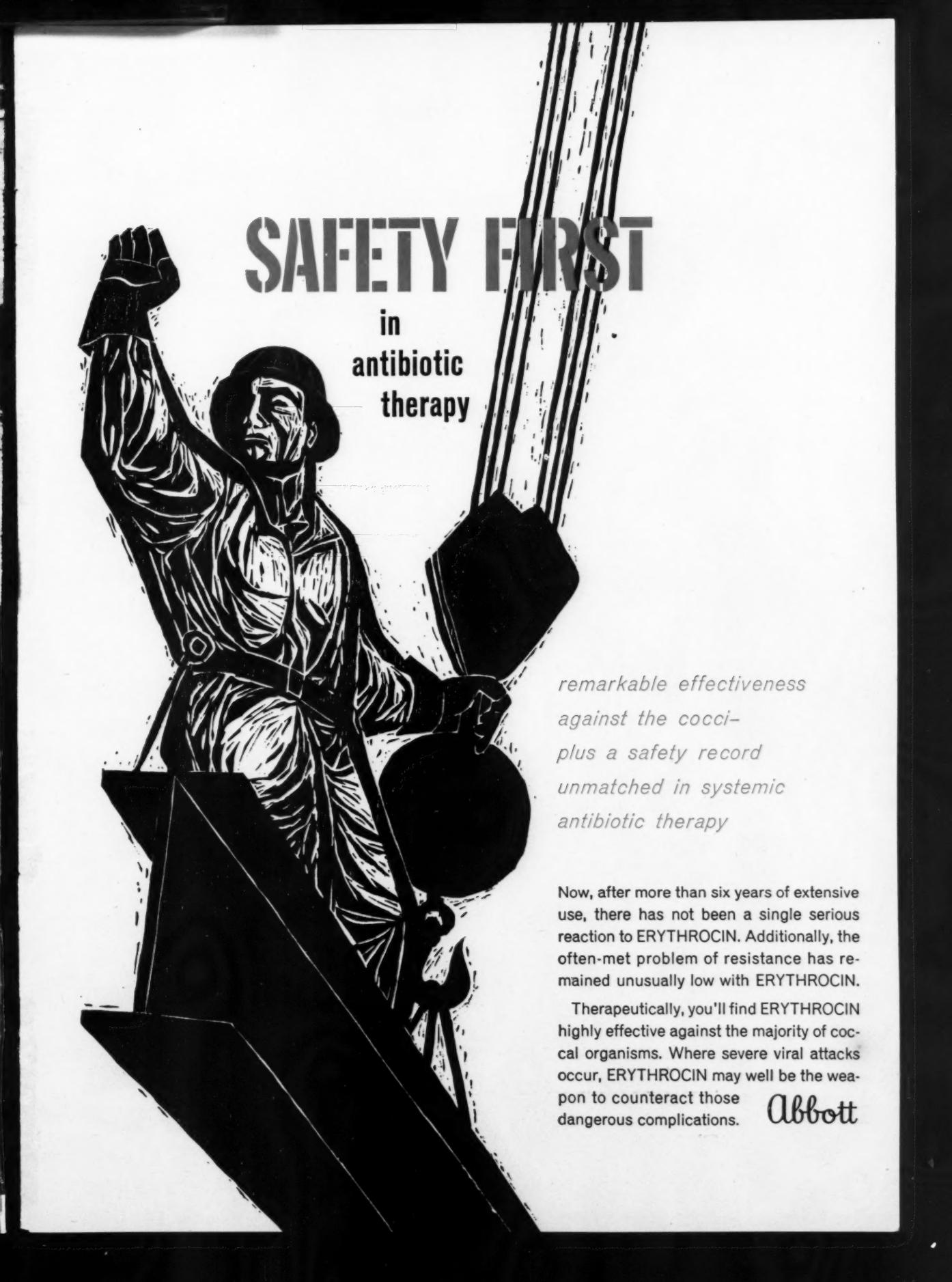
#### *supplied:*

In bottles of 25 and 100 Filmtabs (representing 100 and 250 mg. of ERYTHROCIN activity). Also, in cinnamon-flavored oral suspension; 75-cc. bottles. Each 5-cc. teaspoonful represents 100 mg. of ERYTHROCIN activity.

® Filmtab—Film-sealed tablets, Abbott; pat. applied for.

# SAFETY FIRST

in  
antibiotic  
therapy

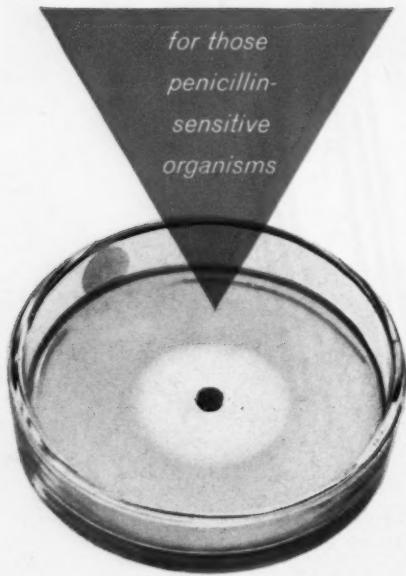


*remarkable effectiveness  
against the cocci-  
plus a safety record  
unmatched in systemic  
antibiotic therapy*

Now, after more than six years of extensive use, there has not been a single serious reaction to ERYTHROCIN. Additionally, the often-met problem of resistance has remained unusually low with ERYTHROCIN.

Therapeutically, you'll find ERYTHROCIN highly effective against the majority of coccal organisms. Where severe viral attacks occur, ERYTHROCIN may well be the weapon to counteract those dangerous complications.

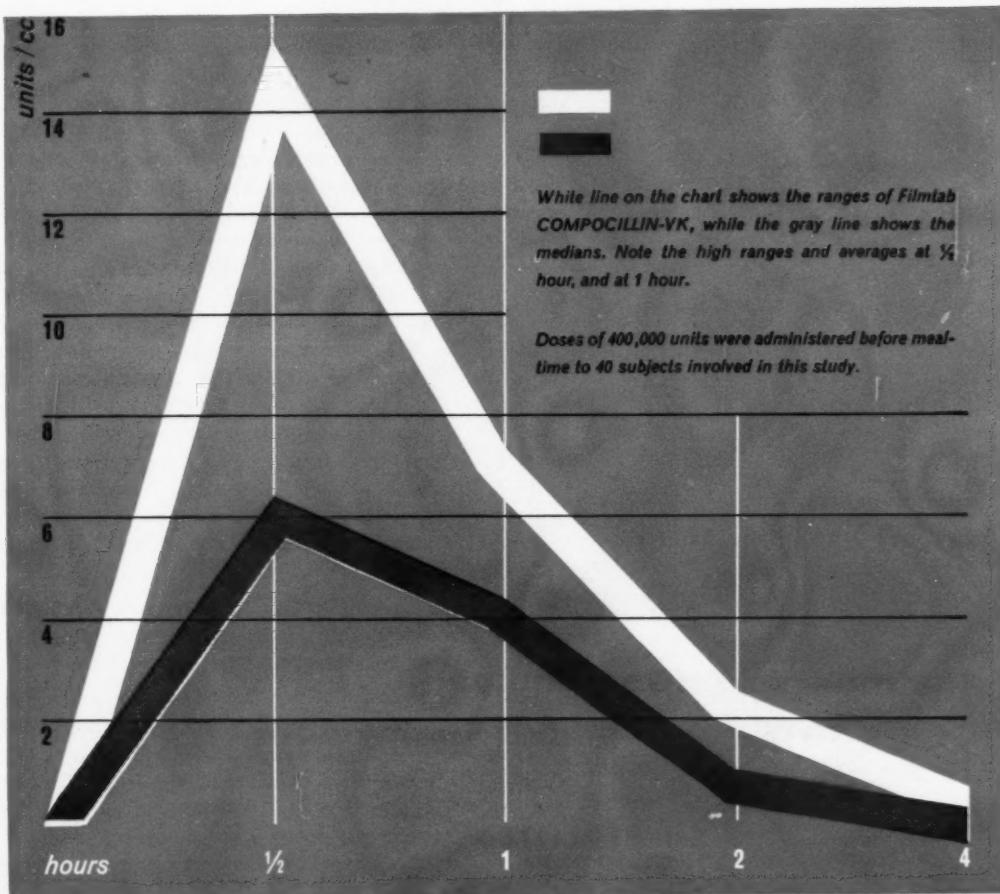
*Abbott*



the **higher** blood levels of

the **higher** blood levels of  
**COMPACT**

Potassium  
Penicillin V



**NOW, IN BOTH FILMTAB AND ORAL SOLUTION,** patients get high penicillin V blood levels with COMPOCILLIN-VK. Note the chart. Concentrations are three times higher than an equivalent dose of potassium penicillin G.

**COMPOCILLIN-VK** is indicated whenever you desire oral penicillin therapy. In severe infections, oral penicillin should be supplemented by parenteral therapy to obtain the maximum therapeutic response.

#### *Indications:*

Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. And as a prophylaxis in rheumatic fever and rheumatic heart disease.

#### *Dosage:*

Depending on the severity of the infection, the usual adult dose is 125 to 250 mg. (200,000 to 400,000 units)

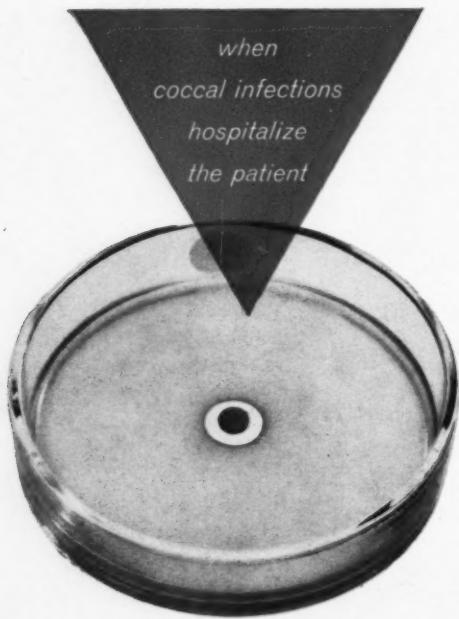
every four to six hours. For children, dosage may be reduced in proportion to body weight.

#### *Supplied:*

In Filmtabs, representing 125 mg. (200,000 units) of potassium penicillin V, bottles of 50 and 100. In 250 mg. (400,000 units), bottles of 25 and 100.

For Oral Solution, COMPOCILLIN-VK comes in dry granules for easy reconstitution with water. Cherry-flavored, the granules come in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoon of solution represents 125 mg. (200,000 units) of potassium penicillin V.

**COMPOCILLIN-V® Oral Suspension (Ready-Mixed).** Hydrabamine Penicillin V, Abbott, comes in 40-cc. and 80-cc. bottles. Each tasty, banana-flavored 5-cc. teaspoonful represents 180 mg. (300,000 units) of penicillin V. At all pharmacies. *Abbott*



**the most effective antibiotic  
available against staphylococci**

CRYSTALLIZED

# SPONTIN<sup>®</sup>

(RISTOCETIN, ABBOTT)

PREPARED FROM PURE CRYSTALS

**Provides Outstanding Clinical Effectiveness Against Coccal  
Infections, Including Resistant Staphylococci and Enterococci<sup>1</sup>**

**Provides Bactericidal Action Against Coccal Infections<sup>1</sup>**

**Provides Successful Short-Term Therapy In Endocarditis<sup>2</sup>**

Now, after just 12 months, SPONTIN has become an outstanding drug of choice against resistant staphylococci, and in other serious coccal infections.

Six papers presented at the Antibiotics Symposium<sup>1</sup> reported the effectiveness of SPONTIN against resistant staphylococcal infections. Clinical responses involved enterococcal endocarditis, staphylococcal pneumonias and staphylococcal bacteremias. Many of these patients were going downhill steadily—in spite of treatment by other antibiotics.

**Toxicity?** Careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals. A recent report<sup>2</sup> in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a safe and potent agent to employ in the treatment of staphylococcal infections."

If you do not have the revised literature on this lifesaving antibiotic, please contact your Abbott Representative soon; or write direct to Abbott Laboratories, North Chicago, Illinois.

**INDICATIONS:** Against a wide range of staphylococcal, streptococcal, pneumococcal and enterococcal infections. A drug of choice for treating serious infections, particularly those caused by organisms that resist all other antibiotics.

**DOSAGE:** Administered intravenously. In pneumococcal, streptococcal and enterococcal infections, a dosage of 25 mg./Kg. will usually be adequate. Majority of staphylococcal infections will be controlled by 25 to 50 mg./Kg. per day. It is recommended that the daily dosages be divided into two or three equal parts at eight- or 12-hour intervals.

**SUPPLIED:** In vials containing a sterile, lyophilized powder, representing 500 mg. of ristocetin A activity.  
Be sure your hospital has it stocked.

*Abbott*

1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.

2. Antibiotics Annual, 1957-58, p. 187-98.

3. J.A.M.A., 167:1584, July 26, 1958.



*Proven*  
in over three years of clinical use  
in over 600 clinical studies

*Specific*  
FOR RELIEF OF ANXIETY  
AND MUSCLE TENSION

*Selective*

Does not interfere with autonomic function

Does not impair mental efficiency,  
motor control, or normal behavior

Has not produced hypotension,  
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)  
**Miltown®**

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

 WALLACE LABORATORIES, New Brunswick, N. J.

*now—an antibiotic troche that*

# STOPS COUGH TOO

The *cough control* provided by homarylamine (a non-narcotic antitussive) approximates that of codeine.

*Three antibiotics* (bacitracin, tyrothricin, neomycin) act in combination against a wide variety of pathogens—with little danger of side reactions. The anesthetic-analgesic effect of benzocaine brings *soothing relief* to inflamed tissues of mouth and throat.

PENTAZETS now extend the therapeutic usefulness of convenient troche medication. Each pleasant-tasting PENTAZETS troche acts promptly against the most bothersome aspects of mouth and throat irritations.

PRESCRIBE

# Pentazets®

antitussive—antibiotic—anesthetic—analgesic troches



MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

*Dosage:* Three to 5 troches daily for 3 to 5 days.

*Supplied:* In vials of 12.

PENTAZETS is a trademark of Merck & Co., Inc.

AN AMES  
CLINIQUICK  
CLINICAL BRIEFS  
FOR MODERN PRACTICE



*which patients  
with noncalculous  
gallbladder  
disease  
should undergo  
surgery?*

Essentially those who are not relieved by a prolonged trial period of medical management.  
*Source*—Lichtenstein, M. E.: GP 16:114 (Oct.) 1957.

*for medical, preoperative,  
postoperative management  
of biliary disorders*

"therapeutic bile"  
**DECHOLIN® and**  
**DECHOLIN SODIUM®**  
corrects biliary stasis

Hydrocholeresis with DECHOLIN produces abundant, thin, free-flowing, therapeutic bile. This flushes thickened bile, mucous plugs and debris from the biliary tract.



AMES COMPANY, INC.

Elkhart, Indiana

Ames Company of Canada Ltd.  
Toronto



## nasal and paranasal congestion and control secondary invaders

Now, a single unique preparation, Trisulfaminic, can provide dramatic relief from congestion, and at the same time protect the patient from secondary bacterial invaders. Often within minutes of the first dose, congestion begins to clear; the patient can breathe again.

Trisulfaminic is particularly valuable for the "almost well" patient who is recovering from influenza but is left with congested nasal and bronchial passages. And for patients with purulent rhinitis, sinusitis or tonsillitis, combination therapy with Trisulfaminic offers a most realistic approach to total treatment.

*Oral Decongestant Action.* Through the action of Triaminic, nasal patency

is achieved rapidly and dramatically. Adequate ventilation helps eliminate mucus-harbored pathogens. And because Trisulfaminic is administered orally, there is no problem of rebound congestion, no pathological change wrought in the nasal mucosa.

*Wide-Spectrum Action.* Secondary bacterial infections, which are always a threat in upper respiratory involvement, are forestalled by the wide-spectrum effectiveness of triple sulfonamides. This added antibacterial protection makes Trisulfaminic highly useful in treating the debilitated patient who is prone to lingering or frequently recurring colds.

# Trisulfaminic

*tablets and  
suspension*

TRIAMINIC PLUS TRIPLE SULFAS

*Each Tablet and each 5 ml. teaspoonful of Suspension contains:*

Triaminic® .....	25 mg.
(phenylpropanolamine HCl .....	12.5 mg.
pheniramine maleate .....	6.25 mg.;
pyrilamine maleate .....	6.25 mg.)
Trisulfapyrimidines U.S.P. .....	0.5 Gm.

**Dosage:** Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

THE RATIONALE  
FOR THE  
USE OF VITAMINS  
IN  
FORESTALLING  
INFECTIONS

Many clinicians believe that good nutrition plays a significant role in preventing bacterial infections, and that immunity depends on adequate vitamin levels. Tisdall<sup>1</sup> states that "a low intake of a number of vitamins, a low intake of minerals, and a change in the quality of protein can all lower resistance to infection."

Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*<sup>2</sup> reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,<sup>3</sup> "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern<sup>4</sup> reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production... nutrition participates in the prophylaxis against most acute infections..."

And while MacBryde<sup>5</sup> feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions... Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

# THERAGRAN

SQUIBB VITAMINS FOR THERAPY

*now expanded to include additional essential vitamins—*

*and at no extra cost to your patients*

*Each Theragran Capsule supplies:*

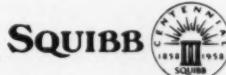
Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Ascorbic Acid	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B <sub>12</sub> Activity Concentrate	5 mcg.

*Dosage:* 1 or more capsules daily as indicated.

*Supply:* Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

*Also Available:* THERAGRAN Liquid, bottles of 4 ounces; THERAGRAN Junior bottles of 30 and 100 capsules; and THERAGRAN-M (Squibb Vitamin-Minerals for Therapy), bottles of 30, 60, 100 and 1,000 capsule-shaped tablets.

*References:* 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, 15:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science 63:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.



*Squibb Quality—The Priceless Ingredient*

# LOW Dosage

# KYNEX\*

Sulfamethoxypyridazine Lederle

for

# G.U.

# Infections



**Unusual Antibacterial and Anti-infective Properties**—More soluble in acid urine<sup>1</sup>... higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.<sup>2</sup>

**Unprecedented Low Dosage**—Less sulfa for the kidney to cope with... yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.<sup>2</sup>

**Dosage:** The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

## KYNEX—WHEREVER SULFA THERAPY IS INDICATED

**Tablets:** Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

**Syrup:** Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

**references:**

1. Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958
2. Editorial: *New England J. Med.* 258:48-49, 1958.

**LEDERLE LABORATORIES**, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

\*Reg. U. S. Pat. Off.



## IN URTICARIA AND PRURITUS

## VISTARIL®

HYDROXYZINE PAMOATE



## A PSYCHOTHERAPEUTIC ANTIHISTAMINE

(as designated by A.M.A. Council on Drugs, 1958)

**SPECIFIC ANTIHISTAMINIC ACTION** in the treatment of a variety of skin disorders commonly seen in your practice.

"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned . . . [hydroxyzine] has been found, by comparison, to be the most potent thus far . . ."<sup>1</sup>

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."<sup>2</sup>

**PLUS**

**PSYCHOTHERAPEUTIC POTENCY** for the relief of anxiety and tension. The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."<sup>3</sup>

**RECOMMENDED ORAL DOSAGE:** 50 mg. q.i.d. initially; adjust according to individual response.

VISTARIL Capsules: 25 mg., 50 mg., 100 mg.

VISTARIL Parenteral Solution: 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. hydroxyzine (as the HCl).

**REFERENCES:**

1. Eisenberg, B. C.: Clinical Medicine 5:897-904 (July) 1958.
2. Feinberg, A. R., et al.: J. Allergy 29:358 (July) 1958.
3. Robinson, H. M., et al.: So. Med. J. 50:1282 (Oct.) 1957.

**Pfizer** Science for the world's well-being

**PFIZER LABORATORIES** Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

\*Trademark

More  
than a  
tranquilizer

# Exactly how does new Halodrin\* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

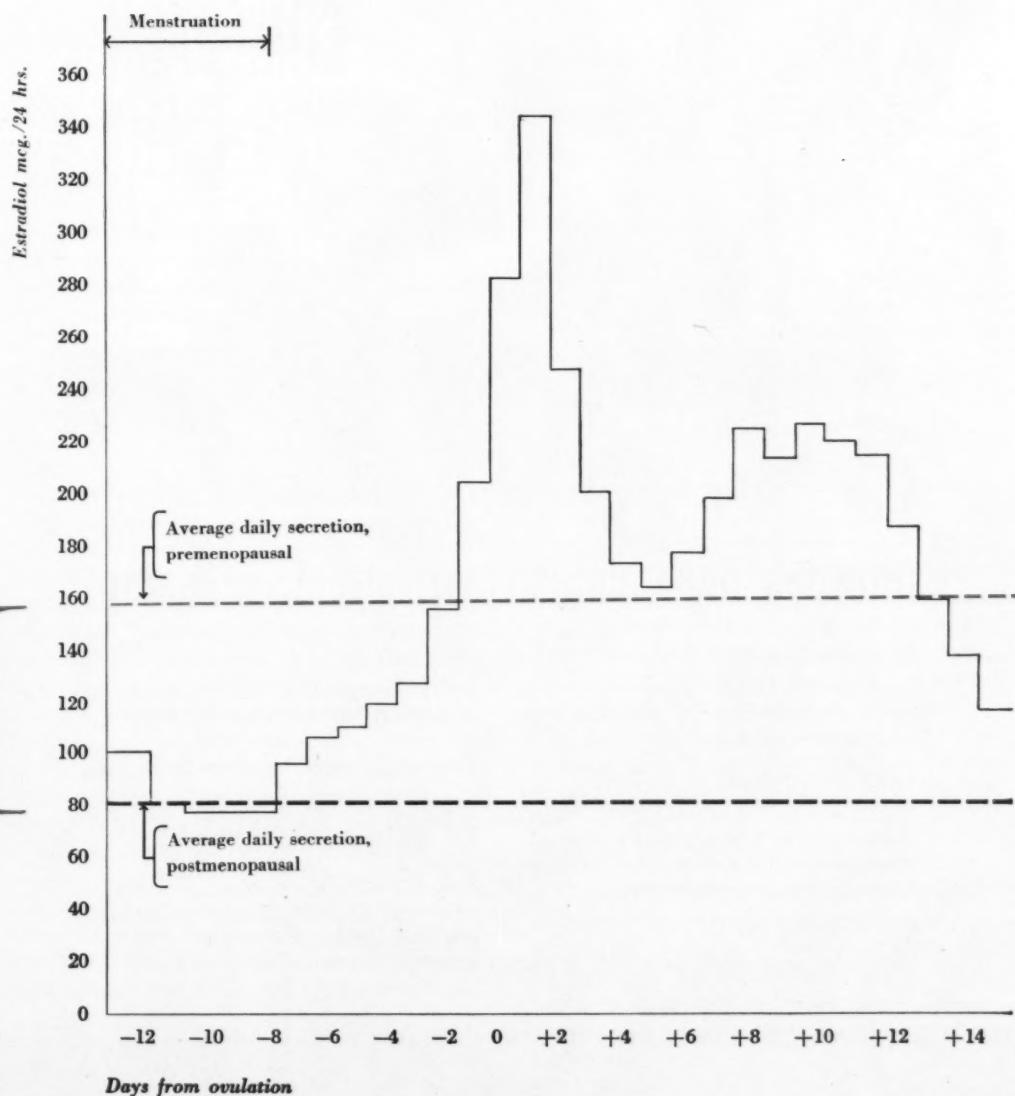
On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin\* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Endogenous estrogen secretion (mcg./24 hours)  
(calculated from average 24-hour urinary excretion  
of estradiol, estrone, and estriol)



*Days from ovulation*



## FOR A QUICK COMEBACK V-CILLIN® K

**provides dependable, fast, effective therapy**

### **dependable action**

because all patients show therapeutic blood concentrations of penicillin with recommended dosages.

### **quick deployment**

of the bacteria-destroying antibiotic. Within five to fifteen minutes after administration, therapeutic concentrations appear in the general circulation.

### **higher blood levels**

than with any other penicillin given

orally. Bactericidal concentrations are assured. Infections resolve rapidly.

**Dosage:** 125 or 250 mg. three times daily.

**Supplied:** Tablets, scored, of 125 and 250 mg. (200,000 and 400,000 units).

**New V-Cillin K, Pediatric:** In bottles of 40 and 80 cc. Each 5-cc. teaspoonful provides 125 mg. V-Cillin K.

V-Cillin® K (penicillin V potassium, Lilly)

# DELAWARE STATE MEDICAL JOURNAL

*Issued Monthly Under the Supervision of the Publication Committee  
Owned and Published by the Medical Society of Delaware*

VOLUME 30

DECEMBER, 1958

NUMBER 12

## THE HEART IN LEUKEMIA

O. J. POLLAK, M.D., PH.D.\*\*

Investigation into the cause of thrombosis and/or hemorrhage often leads to diagnosis of leukemia. Blood vessels may become involved in the pathogenesis of leukemia on the basis of disturbed blood clotting. The heart, too, can be affected by leukemia. This fact is rarely appreciated although pertinent references can be found in medical writings. Several patients with clinical or electrocardiographic evidence of myocardial and/or coronary artery disease in whom leukemia was diagnosed during life or after death were recently encountered. They served as reminders that the heart may be impaired in leukemia in several ways. Four patients were selected as a basis for discussion.

### CASE I

A Negro, aged 18 years, presented with symptoms of precordial oppression, arrhythmia, dyspnea and fatigue interpreted as rheumatic heart disease. His condition responded to bed rest and medication with salicylates but the course was recurrent. One and one-half years after his first visit to a physician palpitation, tachycardia and arrhythmia warranted an electrocardiogram. Changes in the QRS complex, a deep S, and a high R in V<sub>1</sub> were compatible with the diagnosis of rheumatic myocarditis. A month later the patient was hospitalized with pain in the left leg, swelling of the leg, profuse bleeding from the intestines and anemia. These symptoms had an acute onset four days before admission. Shortly afterward the patient developed abdominal pain, nausea and vomiting. He became weak

and short of breath. He twice vomited large amounts of blood, a total of about 500 ml. Temperature was 94°F, respiration rate was 34 and pulse rate was 95 per minute. Blood pressure dropped to 68/40 mm. The patient died within four hours after admission.

Pertinent laboratory findings were: Hematocrit, 24%; hemoglobin, 8.85 gm.; white blood cells, 65,800 per cu. mm.; 2 myelocytes, 1 neutrophilic and 2 eosinophilic segmented cells and 16% lymphocytes. The leukocytes had many toxic granules. The red cells were hypochromic, target cells were present and 1 normoblast was found per 100 white blood cells.

The chief gross necropsy findings were: splenomegaly; hepatomegaly; lymphadenopathy; nodules in spleen, liver, and kidneys; severe pulmonary edema and thrombosis of the left femoral vein. Microscopically, there were massive leukemic infiltrates in spleen, liver, lymph nodes, adrenals, kidneys, in the wall of the small and large intestine and in the myocardium. There was also marked pulmonary edema, pleural and intestinal mucosal petechiae, femoral vein thrombosis and myelofibrosis. The infiltrate between the myofibrils was severe and was seen in sections from various parts of the heart. The character of the cellular infiltrate confirmed the diagnosis of granulocytic leukemia. (Fig. 1)

**Comment:** There was no evidence of rheumatoid carditis. Apparently leukemic myocardial infiltrates simulated rheumatic myocarditis. Terminal thrombosis and hemorrhages were caused by fulminant exacerbation of a chronic aleukemic granulocytic leukemia.

\*Supported by research grant H-2534 (C-1) of the National Heart Institute, N.I.H., USPHS.

\*\*Pathologist, Kent General, Milford Memorial, and Beebe Hospitals; Dover, Milford and Lewes, Delaware.

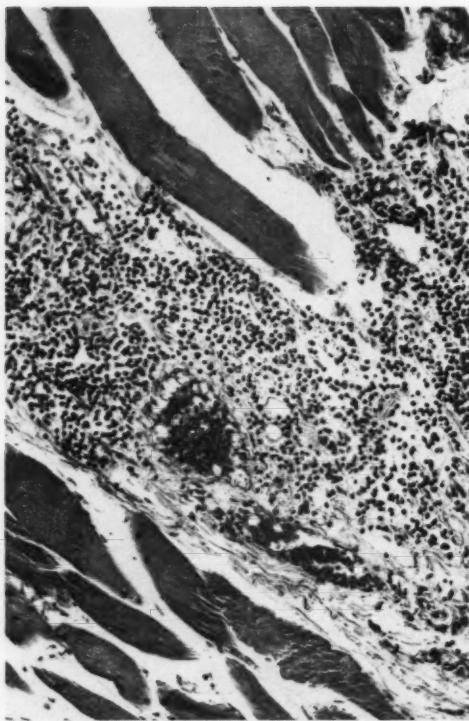


FIGURE 1A (To: CASE 1)  
Leukemic infiltrate of myocardium (x 165)

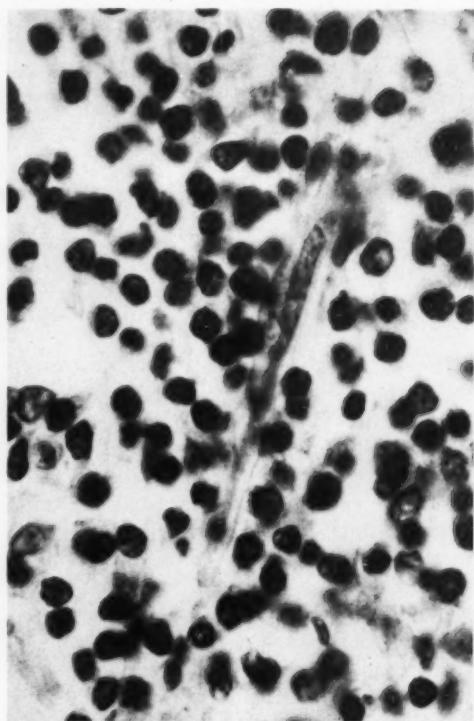


FIGURE 1B (To: CASE 1)  
Myelocytic infiltrate — heart (x 1,200)

#### CASE II

A white man, 74 years old, had to be hospitalized twice within one-half year because of progressive anemia, painful cough and, on second admission, also because of recurrent epistaxis and tarry stools. The patient had no symptoms of heart disease.

On first admission pertinent laboratory findings were: hematocrit, 23%; hemoglobin, 11 gm.; white blood cells, 16,000 per cu. mm.; 4 myelocytes, 3 band forms, 60 neutrophilic segmented cells and 33% lymphocytes. On second hospitalization, four months after the first, the findings were: hematocrit, 17%; hemoglobin, 5.4 gm.; white blood cells, 12,400 per cu. mm.; 4 myelocytes, 3 metamyelocytes, 7 band forms, 42 neutrophilic, 1 basophilic and 2 eosinophilic segmented cells, 40 lymphocytes and 2% monocytes. After six transfusions of 500 ml. whole blood each, the hematocrit rose gradually to 22% and the hemoglobin value to 7.6 gm. The number of myelocytes

exceeded 50% of all nucleated cells in the sternal bone marrow.

The diagnosis of chronic myelocytic leukemia was confirmed by necropsy. Pertinent gross findings were splenomegaly, hepatomegaly and lymphadenopathy. Nodules were seen in the spleen, liver and kidneys. The spleen was about six times the normal size and the liver about twice. The gross appearance of the liver was that of cirrhosis. The surface was coarse nodular, greenish discolored, the architecture was also nodular and the consistency was hard. Microscopically, massive myelocytic infiltrates were seen in the spleen, liver, kidneys, adrenals and bone marrow. Infiltration of the myocardium was much less extensive than that of the other organs. (Fig. 2)

Comment: Apparently leukemic myocardial infiltration was not extensive enough to cause clinical manifestations. In this patient with chronic aleukemic myelocytic leukemia, death was due to anemia and hepatic failure.

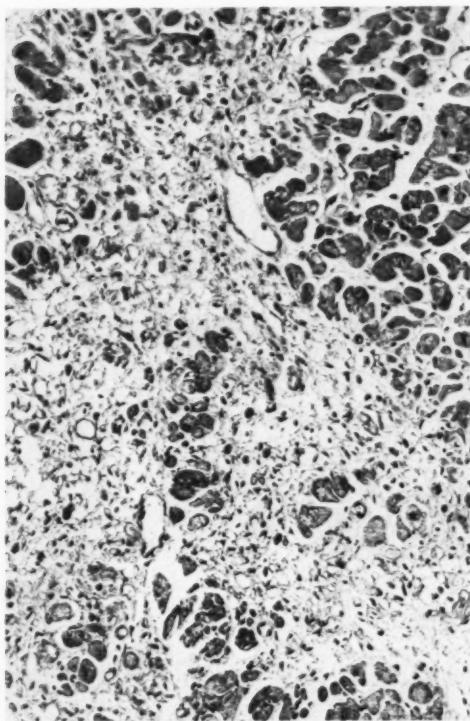


FIGURE 2A (To: CASE 2)  
Leukemic infiltrate of myocardium (x 165)

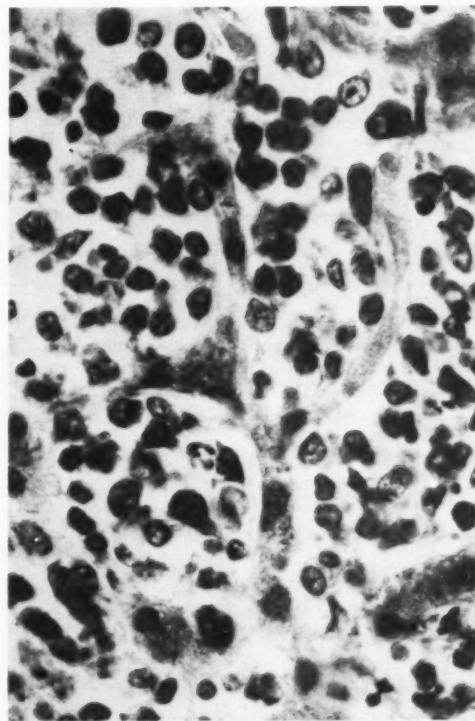


FIGURE 2B (To: CASE 2)  
Myelocytic infiltrate — liver (x 1,200)

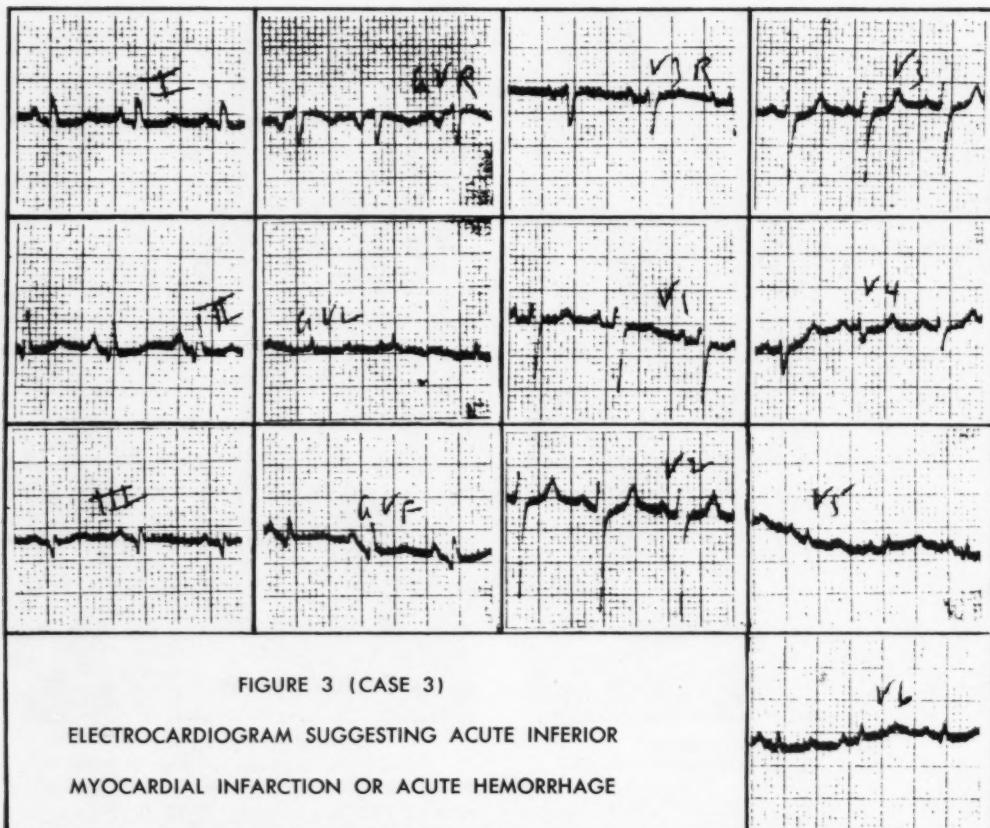
### CASE III

A 58-year old white man was admitted to the hospital because of progressive weakness, fatigue, weight loss over a period of three months and fullness in the hypochondrium. Clinical and radiologic examination disclosed splenomegaly and cholelithiasis. Laboratory data were: hematocrit, 38%; hemoglobin, 10 gm.; white blood cells, 5,200; and 2 days later, 3,000 per cu. mm.; 12 band forms, 80 neutrophilic segmented cells, and 8% lymphocytes; Coombs' test, negative; hemolysis starting at 34 and ending at 30% concentration of sodium chloride solution; prothrombin time, 20 seconds; bleeding time, 3 minutes; clotting time, 20 minutes. Bone marrow examination lead to diagnosis of acute aleukemic myelocytic leukemia.

On admission, the patient's blood pressure was 130/70 mm. On the sixth day the pressure began to decrease rapidly. It reached 68/50 mm. before death. An electrocardiogram was obtained less than 3 hours before death: Normal sinus rhythm,

rate of 112 per minute; P-R, 0.12 seconds; QRS, 0.08 seconds; P normal, S-T normal, T flattened. Amplitude of QRS low in I-III, small complexes in V<sub>4-6</sub>, Q present in III, aVF, V<sub>5-6</sub>. The findings were interpreted as possible early manifestations of an acute anterior infarction or as effect of an acute hemorrhage. (Fig. 3)

At necropsy about 2,000 ml. of liquid blood was found in the abdominal cavity. The spleen measured 40 by 30 by 20 cm. and had a 6 cm. long rent. Several bright red infarcts were present in the spleen. The main splenic artery was occluded by a thrombus. The liver measured 50 by 40 by 15 cm. Nodules were seen in the spleen and liver. Peritoneal and retroperitoneal lymph nodes were enlarged and a deep red color. The bone marrow was voluminous and bright red. The gall bladder contained multiple pigmented, faceted calculi. Microscopically, leukemic infiltrates of considerable extent were seen in the spleen, liver, lymph nodes and bone marrow. There were



no leukemic infiltrates in multiple sections from the myocardium. A fibrous scar after infarction was present in the anterior wall involving the intraventricular septum.

**Comment:** Chronic aleukemic myelocytic leukemia led to splenic artery thrombosis, splenic infarction and rupture with fatal hemorrhage. Electrocardiographic changes were caused by acute hemorrhage rather than by myocardial infarction.

#### CASE IV

A 70-year old white man was under observation for four and one-half months. For about a year before first hospitalization he had anginal attacks which became more frequent. He was admitted because of acute substernal pain, dyspnea and weakness. There was cardiac enlargement and slight edema of the legs. The heart rate was 120 per minute and blood pressure was 118/68

mm. The initial laboratory findings were: hemoglobin, 4.6 gm.; red blood cells, 1,500,000 per cu. mm.; white blood cells, 22,400 per cu. mm.; 11 myelocytes, 6 metamyelocytes, 28 band forms, 21 neutrophilic segmented cells, 29 lymphocytes and 5% monocytes. Five normoblasts were counted per 100 white cells. Diagnosis of chronic myelocytic leukemia was established by bone marrow study.

The first electrocardiogram (Fig. 4-A) obtained on admission pointed to "acute intramural myocardial infarction". There was sinus tachycardia of 120 per minute; P-R, 0.18 seconds; QRS, 0.08 seconds; P generally low, notched in V leads; S-T depressed in II, III, aVF, V<sub>2-6</sub>; T low in all leads.

Nine days later (Fig. 4-B) the tracings were improved so markedly that diagnosis was corrected to "myocardial abnormality;

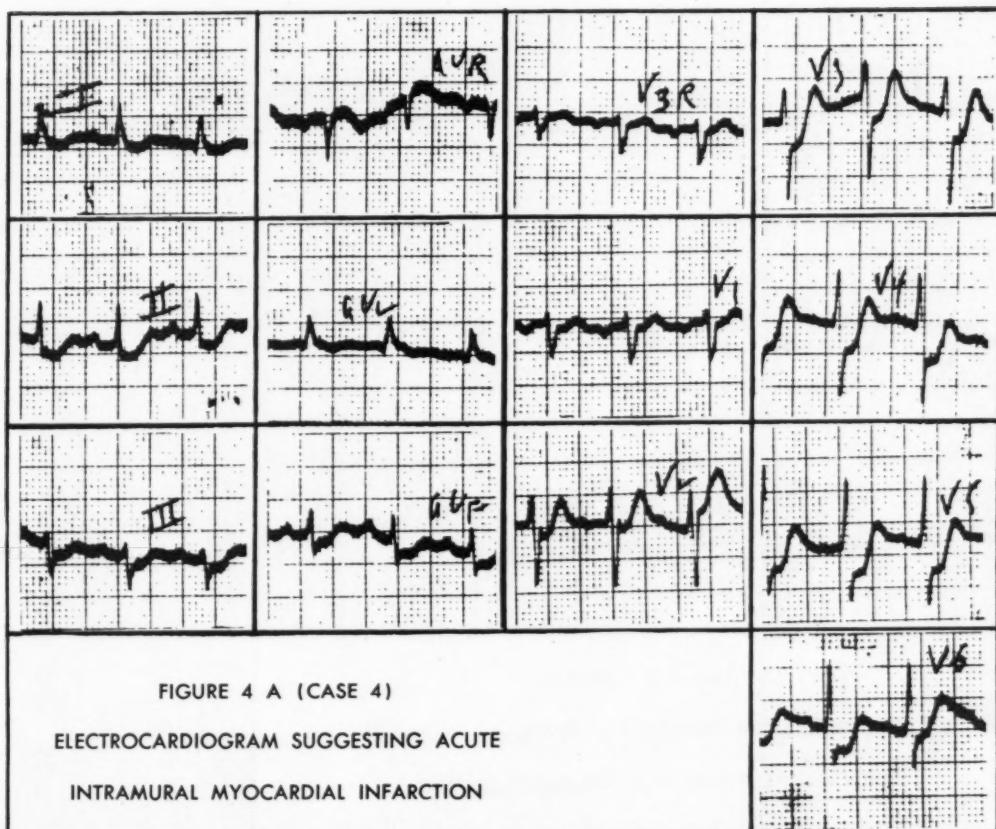


FIGURE 4 A (CASE 4)

ELECTROCARDIOGRAM SUGGESTING ACUTE  
INTRAMURAL MYOCARDIAL INFARCTION

possible recent infarction." The rate was 98 per minute; P generally low; QRS of low amplitude in I-III; S-T slightly depressed in I, II, aVF, V<sub>4-6</sub>; T flattened in I, II, aVF. At this date the hemoglobin was 7.8 gm. after transfusion of 1,500 ml. of whole blood.

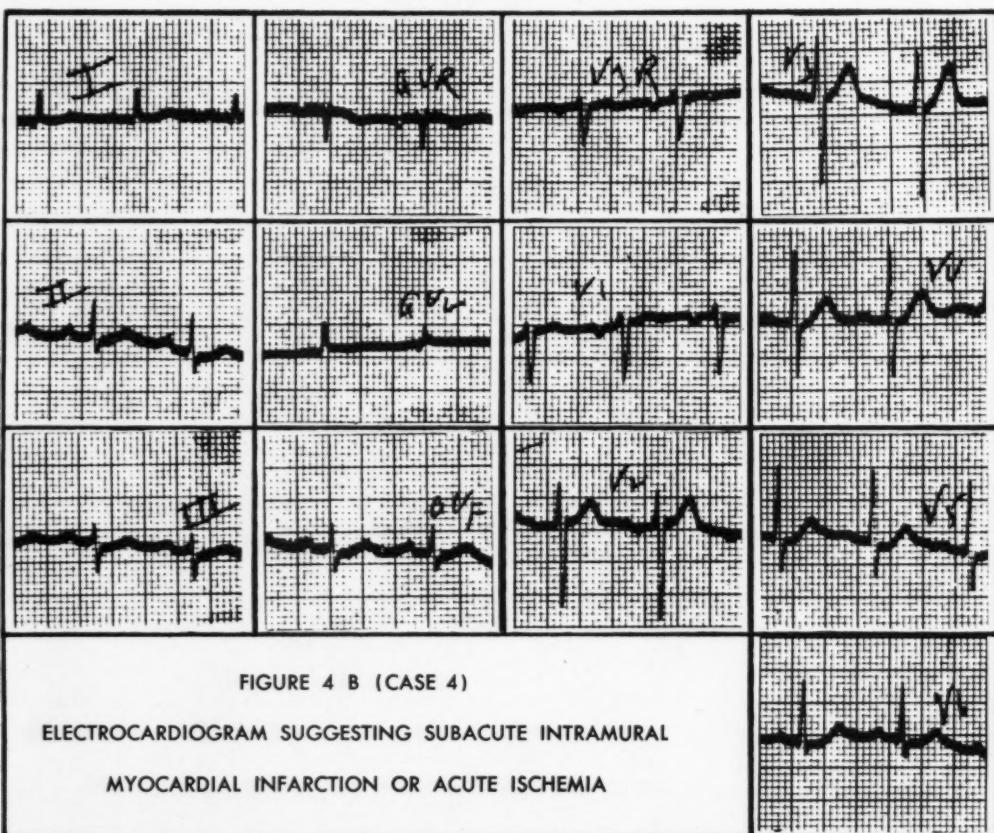
Six days later, or 15 days after the first electrocardiogram, there was further improvement in the tracings (Fig. 4-C). The rate was 93 per minute; P low notched in III, aVF, V<sub>4-6</sub>; QRS were of better amplitude and less deformed than before; S-T normal; T in V leads tended to be tall and symmetric. On this date, after three more whole blood transfusions, the hemoglobin was 9 gm. It became evident that electrocardiographic changes resulted from myocardial ischemia.

In the three-month interval between two hospitalizations the patient received a total

of 32 pints of whole blood. Multiple blood examinations and electrocardiograms revealed parallelism between the degree of anemia and changes in electric conductivity.

Terminal admission was again for severe substernal pain, shortness of breath and profuse perspiration. Laboratory data were: hemoglobin, 5.6 gm., red blood cells, 2,030,000 per cu. mm.; white blood cells, 64,000 per cu. mm.; 7 myelocytes, 11 metamyelocytes, 11 band forms, 36 neutrophilic segmented cells and 16% lymphocytes. The electrocardiogram was similar to the one taken four months before. The rate was 118 per minute; P-R, 0.18 seconds; QRS, 0.08 seconds; QRS, small in I-III; S-T depressed in I-III, aVF, and V<sub>5</sub>; Q prominent in V<sub>6</sub>; T of low amplitude in all leads.

Necropsy confirmed the diagnosis of chronic myelocytic leukemia. There was splenomegaly and hepatomegaly, hyper-



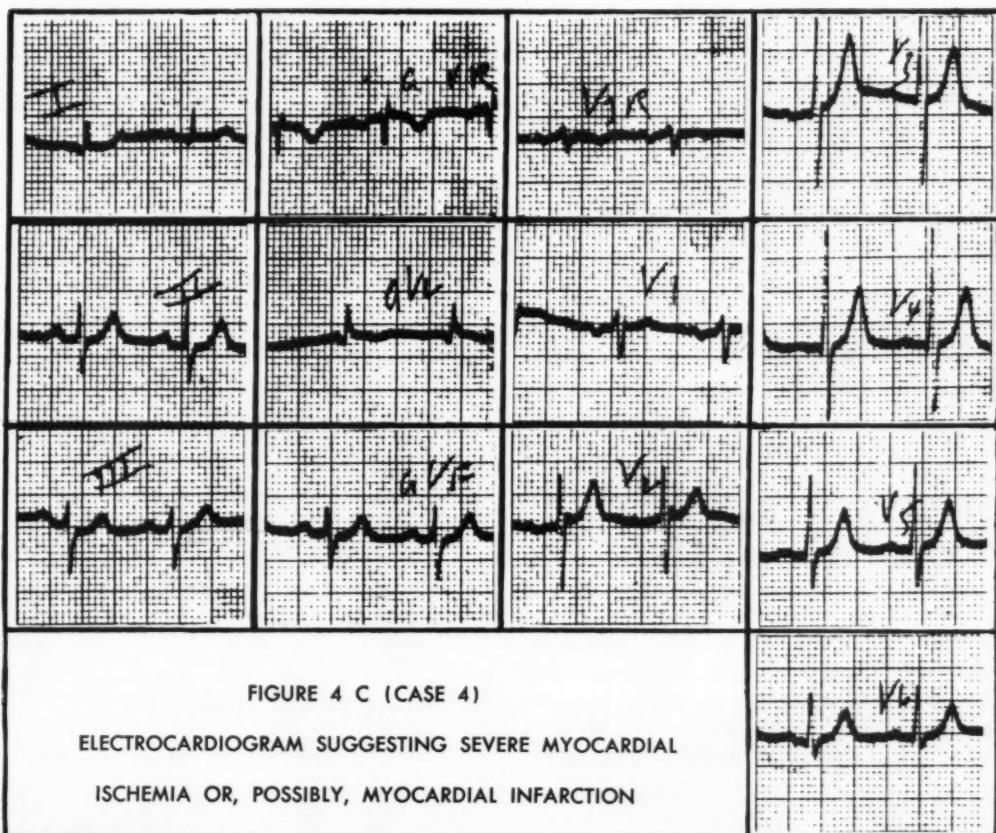
plasia of the bone marrow, petechiae on skin and mucous membranes. Gross nodules were seen in spleen, liver and kidneys. Microscopically, leukemic infiltrates were visible in spleen, liver, kidneys, bone marrow, lymph nodes and adrenals. The heart was slightly enlarged, concentrically. No infiltrates were found in multiple sections of the heart muscle nor was there any evidence of recent or past myocardial infarction. Only isolated yellow plaques were found in the coronary arteries.

**Comment:** Symptomatology of angina pectoris rendered interpretation of electrocardiographic abnormalities difficult. Fluctuation of the changes with the degree of anemia which accompanied the chronic myelocytic leukemia led to correlation of electrocardiograms with the degree of myocardial ischemia.

#### DISCUSSION

Examination of sections from necropsies disclosed the presence of leukemic infiltrates in the myocardium of one third of 19 patients who died from various types of leukemia. In one patient with granulocytic leukemia there were infiltrates in the epicardium but not in the myocardium. Curiously, myocardial infiltrates were found in 6 patients with aleukemic and but one with leukemic myeloid leukemia. This observation does not permit conclusions since the total series is small and myocardial involvement has been described in all forms of leukemia.

In one of our patients (no. 1), myocardial infiltration had caused clinical symptoms of heart disease while such were absent in another patient (no. 2). It is questionable whether this difference was due to the degree or to the localization of the



myocardial infiltrate. Lack of parallel between dissemination and degree of leukemic infiltrates in various organs and myocardial involvement or degrees of myocardial infiltrate is obvious.

All patients with leukemia develop anemia. Patients with the same degree of anemia may not develop the same degree of myocardial ischemia. The latter is more likely to develop in older patients with impairment of circulation due to atherosclerosis. While reading electrocardiograms one should keep in mind that myocardial ischemia can result in abnormalities similar to those in myocardial infarction, that prolonged severe anemia can result in ischemic infarction and also that a patient with leukemia can develop infarction due to coronary thrombosis. Thrombotic episodes are frequent in patients with leukemia. Of the four patients discussed by us one had femoral vein thrombosis (no. 1) and one had

splenic artery thrombosis (no. 3). In a series of 19 patients, from whom the four illustrative cases were selected, 10 had thrombosis. More or less extensive hemorrhages were noted in all 19 patients. Electrocardiographic changes suggesting myocardial infarction, but actually caused by sudden severe hemorrhage, were noted in one patient (no. 3) with rupture of the spleen.

Costa<sup>1</sup> reported rupture of the left atrium due to myeloid infiltration of the myocardium. Wendkos<sup>2</sup> described a case of lymphatic leukemia with massive pericardial and also myocardial leukemic infiltrates. This patient's electrocardiogram had deeply inverted T waves in limb leads. Aronson and Leroy<sup>3</sup> discussed 8 patients with leukemia: Six had sinus tachycardia, S-T depression, T inversion, prolonged P-R, or premature contractions; four had leukemic myocardial infiltration. Blotner and Sos-

man<sup>4</sup> suspected myocardial leukemia in a lady who, after many years of hypertension, developed myeloid leukemia and later, heart block. Left axis deviation and T<sub>4</sub> changes were noted. Upon x-ray therapy to the heart, the leukocyte count reverted from 127,000 per cu. mm. to normal, but the conductive block persisted. Kirshbaum and Preuss<sup>5</sup> observed leukemic involvement of the heart in 42 (34%) of 123 subjects who died of various types of leukemia (53 myeloid, 37 lymphocytic, 28 stem cell and 5 monocytic leukemia). In 19 of the 123 patients leukemia had not been diagnosed during life.

In connection with our report (no. 1) it is of interest that in one of the misdiagnosed patients referred to in the literature<sup>5</sup>, the diagnosis was that of rheumatic heart disease. Apparently, myocardial leukemia and rheumatic myocarditis are rarely confused. Clinical signs of cardiac disease, such as cardiac enlargement, systolic murmurs, tachycardia and palpitation, and exertional dyspnea were ascribed to severe anemia<sup>5</sup> which is a common concomitant of leukemia. Electrocardiographic abnormalities

were generally thought to be caused by leukemic myocardial infarction<sup>2,3,4</sup> though all patients with such abnormalities had severe anemia. Difficulty in differential diagnosis of electrocardiograms between myocardial infarction and ischemia (no. 4) or infarction and severe acute blood loss (no. 3) have not been recorded by others.

#### SUMMARY

Four patients with leukemia presented clinical signs and/or electrocardiographic changes suggestive of myocardial damage on coronary artery disease. Clinical signs and electrocardiographic changes are correlated with necropsy findings.

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## ♦ Editorials ♦

### THE LAW AND THE BLIND

The legal definition of blindness and the Delaware law regarding its reporting appears elsewhere in this issue of The Journal. Within the past few weeks you have received a copy of the Annual Report of Delaware Commission for the Blind. The mandatory reporting of blindness may at first seem like more useless paper-work. Read the report, if you have not already done so; you may be pleasantly surprised at the tremendous job of rehabilitation being carried out in the State of Delaware. The proof of the pudding—the results—well

justify the act. We should do everything within our power to help the Commission continue their mission.

The report contains examples of blind persons who are gainfully employed. This is good and valuable publicity. We must remember that industry is willing to accept these people as well as persons with other physical handicaps and it is our responsibility as physicians to see that the patient gets the proper start on the road to rehabilitation.

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### SCIENCE, THE NEWS, AND THE PUBLIC

A recent report of the National Association of Science Writers, Inc. was published under the above title. Its conclusions were definite but not surprising. The survey established beyond doubt the appreciation of science by the general public and has demonstrated that many readers, listeners, and viewers are willing to give up entertainment features to become better informed about science. Many scientists complain about the manner in which scientific material reaches the public.

Some physicians have argued for years that inasmuch as the public demands medi-

cal information and will get it one way or another, the organized medical profession should assume responsibility for the integrity of the material.

The New Castle County Medical Society has recognized this problem and the report of its Public Relations Committee, published in this issue of The Journal, is an excellent beginning. It seems, however, that the rules finally adopted should be more rigid and should leave less to individual interpretation. It is well to say that we are against evil but first let us define evil.

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### CIVIL SERVANT OF THE YEAR

For the first time in the history of the State of Delaware, the Chamber of Commerce presented an award to a Civil Service employee whose record is outstanding enough to be considered the most proficient in Delaware. No one deserved this honor more than the recipient, a man whose work

is dedicated to helping others. His title is corrective therapist—his work is known commonly as physical rehabilitation—his outstanding performance has been justly recognized. We can be proud that the first recipient of this award has been a person whose work is so closely allied to our own.

## MEDICAL COURT CASES



HOWARD NEWCOMB MORSE

Counsellor at Law

Member of the Bar of the Supreme Court  
of the United States of America

6900 South Shore Drive • Chicago 49, Illinois

### "TENURE OF TREATMENT"

#### CARROLL vs. GRIFFIN

**Court of Appeals of Georgia 96 Ga. App. 826, 101 S. E. 2d 764**

This was an action for alleged malpractice. The Superior Court of DeKalb County, Georgia, entered judgment for the defendant and denied the plaintiff's motion for a new trial, and the plaintiff brought error (appealed). The Court of Appeals of Georgia affirmed the decision of the lower court.

B. O. Carroll was injured in a wreck while riding in a truck owned by Dr. Claude Griffin, a physician. The accident occurred near Carrollton, Georgia. Carroll was first taken to a hospital or clinic in Carrollton and from there to the Georgia Baptist Hospital in Atlanta. Dr. Griffin was shown by the hospital charts to be the admitting physician. Carroll suffered, as a result of the wreck, a fractured left mandible, a fractured zygomatic bone, at least two fractured ribs, fractures to the vertebral column, and a fractured skull.

After Carroll had been in the hospital for approximately five days, Dr. Griffin had a morphine type drug (pantapon) administered to him. Dr. Griffin then had Carroll taken home. Each Sunday thereafter, ex-

cept one, for three or four weeks Carroll was examined by Dr. Griffin. On one occasion Dr. Griffin found that the fractured mandible had slipped out of place and had become a compound fracture where it had previously been a simple fracture. Dr. Griffin set the fracture. Four weeks later Dr. Griffin advised Carroll that he would have nothing further to do with the case. After being so advised, Carroll contacted an attorney in an effort to force Dr. Griffin to furnish him with continued treatment. Carroll was still suffering from some of the injuries sustained in the accident when Dr. Griffin withdrew.

The Court of Appeals of Georgia declared: "There was no evidence that the defendant abandoned the plaintiff at a critical time when there was a need for immediate treatment, for, although the record does disclose that the plaintiff needed surgical treatment, it does not disclose that such treatment was needed then and there or that if the plaintiff had sought within a reasonable time thereafter other medical care he would have suffered any injury from the alleged abandonment."

### "ACCRUAL OF CAUSE OF ACTION FOR MALPRACTICE"

#### SHEARIN vs. LLOYD

**Supreme Court of North Carolina 246 N. C. 363, 98 S. E. 2d 508**

This was a patient's malpractice action against a physician, based on the physi-

cian's failure to remove a lap-pack from the patient's abdomen before closing an appen-

deotomy incision. The Superior Court of Franklin County, North Carolina, rendered judgment for the physician (an involuntary nonsuit against the patient), and the patient appealed. The Supreme Court of North Carolina upheld the decision of the trial court.

The period prescribed in North Carolina for the commencement of an action for malpractice based on negligence is three years from the time the cause of action accrues. The Supreme Court of North Carolina held that the patient's cause of action accrued when the physician closed the incision and was not delayed by the physician's failure thereafter to detect or discover that the lap-pack had not been removed. Inasmuch as the action was not brought within three

years of the time the incision was closed, the action was barred by the statute of limitations.

The Supreme Court of North Carolina stated: ". . . in an action for damages, resulting from negligent breach of duty, the statute of limitations begins to run from the breach, from the wrongful act or omission complained of, without regard to the time when the harmful consequences were discovered . . . It is inescapable that plaintiff's cause of action accrued . . . when defendant closed the incision without first removing the lap-pack from plaintiff's body. Defendant's failure thereafter to detect or discover his own negligence in this respect did not affect the basis of his liability therefore."

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## "PATIENT LEFT UNATTENDED"

**ROBINSON vs. CAMPBELL**

**Court of Appeals of Georgia 95 Ga. App. 240, 97 S. E. 2d 544**

This was an action by the patient for injuries sustained in a fall in the physician's office. The Superior Court of Fulton County, Georgia, dismissed the suit, and the patient appealed.

Miss Allie B. Robinson was a patient of Dr. William E. Campbell, Jr., having been treated by him for an eye condition which resulted in a partial loss of sight by Miss Robinson. Subsequently, she went to Dr. Campbell's office for treatment of her impaired sight. He seated her in a chair designed to be raised or lowered to permit treatment of the eyes of any patient seated in it. She was raised in the chair and a me-

dication of a kind unknown to her was placed in her eyes. She was left in a dependent condition for approximately 30 minutes, the physician's employee-attendants being no longer present. Miss Robinson attempted to get down from the chair, tripped and fell, being injured thereby.

The Court of Appeals of Georgia affirmed the decision of the trial court. The Court of Appeals declared: ". . . the plaintiff was injured by her own act of attempting to get down from the chair which she knew had been raised so as to permit the defendant to examine and treat her eyes."

## NEW CASTLE COUNTY MEDICAL SOCIETY

### Report of the Public Relations Committee

#### A SUGGESTED GUIDE FOR NEWS RELEASE OF MEDICAL NEWS

Physicians, and the hospitals in which they work, and the societies to which they belong, frequently become news, and the center of public interest and comment. This is as it should be, for news is people, places, and situations, fresh information, concerning something that has recently taken place.

Good, accurate medical news, properly released is most desirable, and at times exciting, and members of this society are urged to submit items of interest for consideration of news release . . . which items properly prepared, in good taste and ethics, and most important in fairness and honesty create a most favorable climate of public relations.

The public relations committee in a recent meeting felt that, within the present by-laws, it should be and is available to receive and discuss information of import, and the committee has geared itself to a positive approach whereby rapid review and release of news to authorized channels may be expedited. Your committee reviewed, and sifted procedures followed in other medical societies, and submits for your consideration the better points in the various guides.

The purpose of this guide is to promote a greater and smoother flow of accurate medical news from the medical profession, both those in private practice, and those who work in hospitals, to those engaged in collecting and disseminating such news.

1. To facilitate obtaining such news or information, the society may furnish the responsible news representative with a list of physicians from whom authoritative information may be obtained, or the society may designate the officers, committee chairmen, or other chosen spokesmen of the society, to be available at all times to authorized members of the press, radio, and tele-

vision, in order that authentic information on medical subjects, and news be obtained as promptly as possible.

2. The spokesman may be quoted by name and title. This should not be considered as seeking self-publicity by their colleagues, when such news is sought, and when it is in the best interest of the public and profession and individual physicians. When approached by an authorized representative of a news bureau, seeking information relating to scientific subjects, they are urged to comply unless a premature release be a matter of concern.

3. Photographs of physicians are acceptable, unless the time and place shall indicate self-exploitation. Borderline situations should be cleared with the proper concerned committee chairman or other spokesman chosen by members of this society.

4. Principles of professional conduct shall prevail at all times.

5. The personal privacy and legal rights of all patients shall be protected at all times. When such information is requested, the consent of the patient, be he an important person or not, must be obtained, and the will of the patient is final.

6. When appearing on radio or television programs, and when presented as doctor so and so, sound judgment and good common sense and an adherence to our professional code and conduct are expected of any physician, since he cannot escape the implication of representing the profession or his medical society.

7. Cooperation with authorized reporters is desirable, but should the item or topic be unripe or unwise for release at the time, a frank discussion of the topic and reason for delay is wise. We feel that the reporter

will cooperate, with valid reasons, and will not indulge in news by inference or ghost reporting or a negative approach.

8. The Board of Censors may discipline for non-cooperation with these suggestions, if adopted.

Equally important to the ultimate success of this endeavor, is the manner in which news is released by the hospitals of this area, whose medical staffs are almost wholly composed of members of this society. These plans must be the product of the administrative bodies of the individual institution, who can best suit the particular need. We

do feel, however, that a coordinated manner of news release will serve everyone best, and keep a conflicting opinion or situation from occurring.

These suggestions, which we consider quite fundamental, are presented for your consideration, and we urge you to adopt them.

Respectfully submitted,  
William O. LaMotte, Jr., M.D.  
Charles E. Maroney, M.D.  
James T. Metzger, M.D.  
Alexander Smith, M.D.  
Charles T. Lawrence, M.D., Chairman

#### DEFINITION OF BLINDNESS

"Blind person" means one who is totally blind or has visual acuity of not more than 20/200 in the better eye with best correc-

tion, or whose vision is limited in field so that the widest diameter subtends an angle no greater than 20 degrees.

#### MANDATORY REPORTING

The laws of the State of Delaware (Title 31, Section 2109) require that every health and social agency, attending or consulting physician, or nurse, shall report to the Commission for the Blind, in writing, the name, age and residence of persons who are blind within the definition of blindness as indicated above, and in such cases shall furnish

such additional information as the Commission requests for registration or prevention of blindness.

The Commission respectfully urges that this requirement of Delaware law be diligently adhered to in order that all blind citizens may know the services available to them, and benefit accordingly.

## PROCEEDINGS OF THE HOUSE OF DELEGATES

The meeting of the House of Delegates of the Medical Society of Delaware was called to order in the Dover Hotel, Dover, Delaware, on Sunday, September 28, 1958, at three-thirty o'clock. Dr. John B. Baker, President of the Society, called the meeting to order and after the roll call, declared a quorum to be present. The reports of the officers and committees were presented as follows:

### REPORT OF SECRETARY

To House of Delegates  
Medical Society of Delaware

The office of the Secretary has been conducted on a current basis during the past year. Minutes of the Council meetings have been kept. The Secretary has also assisted in the negotiations with the Department of Defense with regard to Medicare program.

Respectfully submitted,  
NORMAN L. CANNON, M.D.  
Secretary

### REPORT OF THE EXECUTIVE SECRETARY

There is no practical way for me to present through the relatively short medium of an annual report to the House of Delegates the daily work of the headquarters office for a period of twelve months. Most of the Society's accomplishments and failures during this time appear in the reports of its committees, and most of these have involved staff work to greater or less degree. For me to detail the efforts and special problems of each group would be repetitious and of no purpose. I would prefer, rather, to discuss the topics that fall, as it were, between the areas of committee responsibility, and have had, therefore, to be handled either as a part of the staff work or on an adhoc basis.

The Executive Secretary reports that the membership of the Society stands at 414, distributed among the counties as follows:

Kent County Medical Society	31
New Castle County Medical Society	326
Sussex County Medical Society	57

### ANNUAL MEETING

The lack of good convention facilities in the state of Delaware remains a problem. Within the narrow limits of availability, the duPont Country Club offers the best site obtainable this year. We have been able to provide twenty-eight booths, which will accommodate twenty-five technical and three scientific exhibits. Applications for space in both categories have had to be rejected, simply because we had no place to put them. Revenue from exhibits is \$1,270 this year, lower than last year, and than 1953, higher than at any other annual meeting. This was accomplished by raising exhibit rates, not by the preferable method of providing more space to accommodate more exhibits. Exhibit revenue still fails to provide the 50% of annual meeting cost that would be a desirable minimum, and will probably continue to do so until good convention facilities exist.

The exhibit background panels designed and purchased last year have been wired for electricity,

enabling us to receive higher rental for their use. They have now paid for themselves completely and returned a net profit. We can anticipate a return on the investment of from \$400-\$500 per year for use in presenting the Annual Meeting, before it becomes necessary to replace them.

I should like again to remind the Society that the exhibitors' attendance and the help they provide is dependent upon each member's accepting the responsibility of visiting the exhibits and providing the contact with physicians for which these firms are paying.

### POLIO INOCULATION CAMPAIGN

With the cooperation of the State Board of Health and the Delaware Chapters of the National Foundation for Infantile Paralysis, the series of free public polio clinics has been completed. The Board of Health's figures show a total of 344,837 doses of vaccine given through the clinics, the school program, and the field trials. The Board also estimates that 211,094 doses of the vaccine were given by physicians in private offices. The results show that approximately 85% of the child population from birth through 19 years of age has had three doses of vaccine, while about 7% more have had one or two doses. The group from 20-45 has 35% complete coverage, with an additional 17% incompletely. Assessed in terms either of public health or public relations, the results of this campaign have been excellent. The Society has reason to be grateful to the radio and the press for their outstanding cooperation. Appropriate letters of thanks have been sent. As a specific gesture of thanks, the News Journal Company was invited to send a representative to the AMA-National Science Writers Association meeting on writing medical news. Mr. Cy Liberman attended this as the Society's guest, in company with the Executive Secretary.

### MEDICARE

The Medicare program has continued in operation. For the period September 1, 1957 through August 31, 1958, physician payments in Delaware have totalled \$190,298 for 2539 patients. Under the authority of the 1957 House of Delegates a new contract was negotiated in Washington April 14, and became effective May 1. The revisions in the program that became effective October 1, and of which all members of the Society have been notified, materially reduce the services payable and the eligibility of patients for Medicare. The Department of Defense is under mandate from the Joint Senate-House Committee on Defense Appropriations to confine Medicare spending to 72 million dollars. It appears that this will be done even at the cost, if necessary, of suspending the program until appropriations can be voted for the next fiscal year. While pressure for restrictions appears to have originated with the services, the Congress is responsible for their imposition. This should be kept in mind when explanations are called for.

The Society's thanks are due Group Hospital Service, Inc., which continues to act as fiscal agent for the Medicare program on a non-profit basis.

## JOURNAL

The Executive Secretary continues to manage the business of the Delaware State Medical Journal. Having shown an operating gain for three consecutive years, the Journal has recouped its losses and appears to be in good financial condition. While it still does not bear a realistic share of its own cost, it has built a cash reserve which stands to the Society's credit, and is now in a position to contribute financially to the Society's operation. The Publications Committee has realized this and plans this year to assume a proportionate share of the office rent and to provide service and equipment which would not otherwise be available.

Prospects for the coming year are complicated by plans to change from one printer to another at what are expected to be increased rates. This will lower the Journal's margin for operations, but will be offset to some extent by an increase in advertising rates. We expect greatly improved service to result from the change. If advertising volume remains about the same, the Journal should show a small gain for the coming year and stabilize at about cost after that, at which time it will be spending about \$2500 more a year than at present on its own improvement and contributing in excess of \$1000 per year to the Society's operating expenses.

The report of the Committee on Public Laws deals with the Society's legislative activities, which I do not wish to repeat here. I do want to make the point that the one most imperative bill in the General Assembly to be stopped was stopped, and that this was done in the face of determined well-organized opposition through the personal participation in the effort of a substantial number of physicians. The Legislative climate toward physicians is still not at the optimum, but the great improvement resulting from the polio effort has been added to by this demonstration of solidarity.

Our congressional delegation was visited in Washington and has received the Society's views upon specific issues. They have shown unfailing courtesy, and have been, on the whole, responsive to the Society's requests.

## HEADQUARTERS OFFICE

The acquisition of Mrs. Winifred Donnelly as Office Secretary and of the beginnings of a modern office have benefited the Society. Mrs. Donnelly devotes many hours of uncompensated time to this organization and her presence has made possible the complete reorganization of the office and of the vast amount of unsorted, uncatalogued material that has accumulated over the years. For the first time, the Society has usable informative files. The reorganization of this material will be completed with the institution this winter of completely new membership records, to be done concurrently with publication of the bi-annual roster. This reorganization has consumed a great deal of time through the year, but, once done, should be relatively easy to maintain.

I want, in conclusion, to express my appreciation to the officers and members of each county society for their courtesy and hospitality when I have visited them, and to the Medical Society of Delaware as a whole for the pleasure of working with the physicians of Delaware during the year past.

Respectfully submitted,  
LAWRENCE C. MORRIS, JR.  
Executive Secretary

## REPORT OF THE TREASURER

Gentlemen:

We have examined the financial records of the Treasurer of the Medical Society of Delaware and of the Delaware State Medical Journal for the year ended July 31, 1958, the results of which are included in this report, consisting of the commentary and the following statements:

Title:	Exhibit and/or Schedule
Balance sheet at July 31, 1958	A
Statement of cash receipts and disbursements for the year ended July 31, 1958:	
General fund	B
Delaware State Medical Journal	C
Budgetary statement of revenue and expenditures for the year ended July 31, 1958:	
General fund	D
Statement of securities owned at July 31, 1958 and income therefrom during the year then ended:	
General fund	A-1
Reconciliation of dues and A.M.A. assessments for the seven months ended July 31, 1958:	
General fund	B-1

## HISTORY

At the 1957 annual session, the House of Delegates approved an amendment to the by-laws of the society, changing its fiscal year from December 31, to July 31, and, under separate cover, we have submitted an audit report for the year ended December 31, 1957. However, for future convenience in comparisons and budgeting, the financial statements of this report include operations for the year ended July 31, 1958, so that the operations for the period August 1, 1957 to December 31, 1957 are included in both reports. The budgetary statement included in the report for the fiscal year ended July 31, 1958 was originally adopted for the calendar year 1958.

Information returns, required by federal statutes, have been prepared for both the year ended December 31, 1957 and the seven months ended July 31, 1958 and, form 1128, Application for Change in Accounting Period, has been filed with the U. S. Treasury Department.

## SCOPE OF EXAMINATION

Testings were made of income and expense factors in both the Treasurer's records and those of the Delaware State Medical Journal to the extent we deemed appropriate in the circumstances. Cash received was traced to deposits in bank and expenditures were verified by reference to canceled checks and/or vendors' invoices. Cash in banks as of July 31, 1958 was confirmed direct to us by the various depositories and was reconciled with the book balances therefor at that date. Securities owned at July 31, 1958 were examined by us at the Bank of Delaware on September 17, 1958 in the presence of Charles Levy, M.D. and income earned thereon during the period under review was verified by recomputations or reference to accredited financial publications. Other verifications deemed necessary are commented upon in the ensuing paragraphs of this report.

## COMMENTARY

A statement of financial condition at July 31, 1958 is presented in exhibit A; while statements

of cash receipts and disbursements for both funds, showing a segregation of operations for the months of August through December 1957 and January through July 1958, are included herein as exhibits B and C, respectively. A budgetary statement of operating factors within the General fund, using the anticipated revenues and appropriated expenditures originally approved for the calendar year 1958, is presented in exhibit D. The society maintains three separate savings accounts, the transactions of which are not included in the operating statements of this report but the changes therein during the period under review are detailed in the following tabulation:

	REGULAR FUND Wilmington Savings Fund Society	STATE MEDICAL JOURNAL Wilmington Savings Fund Society	Wilmington Trust Company	
BALANCES, JANUARY 1, 1957	\$4,805.08	\$3,626.53	\$1,719.30	

## RECEIPTS:

## Interest earned:

Period 1-1-57

to 12-31-57 .....	\$ 156.16	\$ 117.84	\$ 28.76	
Period 1-1-58	.....	.....	17.48	
to 7-31-58 .....	.....	.....	.....	
	\$ 156.16	\$ 117.84	\$ 46.24	
	\$4,961.24	\$3,744.37	\$1,765.54	

## DISBURSEMENTS:

None .....	.....	.....	.....	
	\$4,961.24	\$3,744.37	\$1,765.54	

The current effective rate of earnings in these accounts is 3½% per annum at the Wilmington Savings Fund Society and 2% at Wilmington Trust Company. Wilmington Trust Company credits interest to its savings accounts semi-annually at June 30 and December 31; while the Wilmington Savings Fund Society credits interest to its accounts annually on December 31. The balances shown, therefore, include interest earned through June 30, 1958 at the Wilmington Trust Company and through December 31, 1957 at the Wilmington Savings Fund Society.

At the 1957 annual session, the House of Delegates approved a transfer of the Medical Defense fund to the General fund balance account but indicated that a reserve of \$1,000.00 should be retained within the latter fund for possible legal litigation. The Defense fund comprised the savings account shown in the foregoing tabulation, which for purposes of this report is indicated to be General fund cash and the reserve account has been adjusted to show a fixed balance of \$1,000.00 as authorized.

## RECOMMENDATION

In our opinion, the Delaware State Medical Journal should function within budgetary restrictions and closer supervision should be exercised over the appropriations within the General fund. The Treasurer of the Society should not be expected to assume the detailed supervision this would entail but should merely review trends throughout the year as he deemed desirable. We suggest the actual record keeping, depositing of funds, issuance of checks and preparation of reports be transferred to the office of the Executive Secretary. The Treasurer would retain the au-

thority to sign checks but the transfer of records proposed would relieve him of certain detailed accounting functions and it would permit all records of the Society to be retained in a central location.

## CONCLUSION

In our opinion, the accompanying balance sheet and related statements of cash receipts and disbursements present fairly the financial position of the Medical Society of Delaware at July 31, 1958 and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with the preceding period.

We wish to express our appreciation for the courtesies extended to us during the course of this examination.

Very truly yours,  
HAGGERTY & HAGGERTY  
Certified Public Accountants

## Exhibit A

## Balance Sheet at July 31, 1958

## ASSETS

## GENERAL FUND:

Cash in bank:			
Regular account—			
exhibit B .....	\$19,467.30		
Savings account .....	4,961.24		
			\$24,428.54
Investment—			
schedule A-1:			
Stocks .....	12,201.08		
Government bonds .....	5,040.00		
			17,241.08
Due from State			
Medical Journal .....	222.76		
			\$41,892.38
DELAWARE STATE			
MEDICAL JOURNAL:			
Cash in bank:			
Operating account—			
exhibit C .....	7,204.98		
Savings accounts .....	5,509.91		
			12,714.89
Investments—			
Government bonds .....	3,502.38		
			16,217.27
			\$58,109.65

## LIABILITIES AND FUND BALANCES

## GENERAL FUND:

Liabilities:			
Employees' withholdings and accrued payroll taxes .....		\$ 191.81	
Reserve:			
Defense fund .....		1,000.00	
Fund balance .....		40,700.57	
			\$41,892.38

## DELAWARE STATE

## MEDICAL JOURNAL:

Liabilities:			
Due to General fund.. \$ 222.76			
Fund balance .....		15,994.51	
			16,217.27
			\$58,109.65

## Exhibit B

**General Fund**  
**Statement of Cash Receipts and Disbursements**  
**For the Year Ended July 31, 1958**

	Total	7 Months Ended 7-31-58	5 Months Ended 12-31-57
<b>BALANCES, BEGINNING OF PERIOD</b>	<b>\$18,718.83</b>	<b>\$10,592.29</b>	<b>\$18,718.83</b>
<b>RECEIPTS:</b>			
Dues:			
State Society .....	17,319.50	16,967.00	352.50
A.M.A. ....	9,112.50	8,925.00	187.50
Subscriptions—Medical Journal .....	1,111.50	1,083.00	28.50
	<u>27,543.50</u>	<u>26,975.00</u>	<u>568.50</u>
Annual session—proceeds of ticket sales .....	1,400.00	.....	1,400.00
Annual session—rent exhibit space .....	1,245.00	250.00	995.00
Income from investments .....	660.50	330.50	330.00
Medical Journal—rent and stenographer .....	480.00	280.00	200.00
Reimbursement—travel .....	188.80	188.80	.....
Registration—seminar .....	55.00	55.00	.....
Reimbursement—postage .....	41.71	.....	41.71
Women's auxiliary—reimbursement files .....	38.36	38.36	.....
A.M.A.—1% reimbursement collection of dues .....	37.88	1.88	36.00
Group hospital—medicare program .....	23.84	23.84	.....
Employees' withholdings .....	1,408.65	940.60	468.05
	<u>33,123.24</u>	<u>29,083.98</u>	<u>4,039.26</u>
<b>BEGINNING BALANCES AND TOTAL RECEIPTS</b>	<b>51,842.07</b>	<b>39,676.27</b>	<b>22,758.09</b>
<b>DISBURSEMENTS:</b>			
Salaries:			
Executive secretary .....	6,683.33	4,183.33	2,500.00
Stenographer .....	2,275.00	1,650.00	625.00
Payroll taxes—Society's share .....	201.56	131.25	70.31
	<u>9,159.89</u>	<u>5,964.58</u>	<u>3,195.31</u>
Operations:			
Subscriptions to Journal .....	1,153.50	1,059.00	94.50
Contributions .....	1,055.00	.....	1,055.00
Office furniture (38.36 refunded—contra) .....	1,032.14	527.42	504.72
Symposium .....	100.00	.....	100.00
	<u>3,340.64</u>	<u>1,586.42</u>	<u>1,754.22</u>
Office:			
Rent and electric .....	\$ 1,026.28	\$ 627.92	\$ 398.36
Printing, stationery and postage .....	797.71	430.81	366.90
Telephone and telegraph .....	322.58	169.41	153.17
Subscriptions .....	83.00	48.00	35.00
Rent—safe deposit box .....	5.50	5.50	.....
Miscellaneous .....	18.00	.....	18.00
	<u>2,253.07</u>	<u>1,281.64</u>	<u>971.43</u>
Travel:			
A.M.A. delegate (\$188.80 refunded—contra) .....	1,236.54	1,017.24	219.30
A.M.A. conference .....	219.25	219.25	.....
Guest speaker .....	100.00	.....	100.00
Local .....	377.95	255.58	122.37
	<u>1,933.74</u>	<u>1,492.07</u>	<u>441.67</u>
Annual session:			
Meals and entertainment .....	2,160.00	.....	2,160.00
Stenotypist .....	652.50	.....	652.50
Rent of hall .....	528.60	.....	528.60
Program and tickets .....	438.30	.....	438.30
Exhibits .....	474.15	.....	474.15
Badges .....	82.97	.....	82.97
Miscellaneous .....	69.00	.....	69.00
	<u>4,405.52</u>	.....	<u>4,405.52</u>
Other:			
A.M.A. assessment .....	9,562.50	8,850.00	712.50
Withholdings—due from "Journal" .....	222.76	121.29	101.47
Dues refunded .....	75.00	75.00	.....
Employees' withholdings .....	1,421.65	837.97	583.68
	<u>11,281.91</u>	<u>9,884.26</u>	<u>1,397.65</u>
<b>BALANCES, END OF PERIOD</b>	<b>\$19,467.30</b>	<b>\$19,467.30</b>	<b>\$10,592.29</b>

## Exhibit C

**Delaware State Medical Journal**  
**Statement of Cash Receipts and Disbursements**  
**For the Year Ended July 31, 1958**

	Total	7 Months Ended 7-31-58	5 Months Ended 12-31-57
<b>BALANCE, BEGINNING OF PERIOD</b>	<b>\$ 3,658.28</b>	<b>\$ 3,424.94</b>	<b>\$ 3,658.28</b>
<b>RECEIPTS:</b>			
Subscriptions:			
Members .....	1,177.50	1,083.00	94.50
Single copies .....	22.76	17.51	5.25
Other subscriptions .....	203.54	180.54	23.00
	1,403.80	1,281.05	122.75
Advertisements .....	23,974.43	15,512.75	8,461.68
Interest—U. S. Government bonds .....	87.50	43.75	43.75
Proceeds—sales of rosters .....	4.00	4.00	.....
Royalties .....	.53	.53	.....
Employees' withholdings .....	134.61	79.51	55.10
	25,604.87	16,921.59	8,683.28
<b>BEGINNING BALANCES AND TOTAL RECEIPTS</b>	<b>29,263.15</b>	<b>20,346.53</b>	<b>12,341.56</b>
<b>DISBURSEMENTS:</b>			
Salaries:			
Editor .....	3,000.00	1,750.00	1,250.00
Others .....	205.00	145.00	60.00
	3,205.00	1,895.00	1,310.00
Publishing costs .....	17,862.63	10,789.70	7,072.93
Rent and stenographer .....	480.00	280.00	200.00
Stationery and postage .....	102.45	59.00	43.45
Insurance—bonding .....	92.85	92.85	.....
Stenographer symposium .....	65.00	.....	65.00
Registration fee—copyrights .....	48.00	.....	48.00
Miscellaneous .....	102.34	25.00	77.34
Employees' withholdings .....	99.90	.....	99.90
	22,058.17	13,141.55	8,916.62
<b>BALANCES, END OF PERIOD</b>	<b>\$ 7,204.98</b>	<b>\$ 7,204.98</b>	<b>\$ 3,424.94</b>

## Exhibit D

**General Fund**  
**Budgetary Statement of Revenue and Expenditures**  
**For the Year Ended July 31, 1958**

	Anticipated	Realized	Excess Deficit
<b>REVENUE:</b>			
<b>Dues—current</b>			
Annual dinner .....	\$19,000.00	\$18,431.00	\$ 569.00
Exhibit rentals .....	750.00	1,400.00	650.00
Dividends .....	700.00	1,245.00	545.00
Medical Journal—rent and stenographer .....	500.00	660.50	160.50
A.M.A. reimbursement—dues processed .....	480.00	480.00	.....
Registration—seminar .....	70.00	37.88	32.12
	55.00	55.00	.....
	<hr/> \$21,500.00	<hr/> \$22,309.38	\$ 809.38
<b>EXPENDITURES:</b>			
<b>Salaries:</b>			
Executive secretary .....	\$ 7,000.00	\$ 6,683.33	\$ 316.67
Stenographer .....	3,000.00	2,275.00	725.00
Payroll taxes—Society's share .....	160.00	201.56	41.56
	<hr/> 10,160.00	<hr/> 9,159.89	1,000.11
<b>Operations:</b>			
Committees .....	1,575.00	.....	1,575.00
Subscriptions to journal .....	1,275.00	1,153.50	121.50
Contribution—Delaware Academy of Medicine .....	1,000.00	1,000.00	.....
Auditor .....	200.00	.....	200.00
Miscellaneous .....	200.00	.....	200.00
Symposium .....	.....	76.16	76.16
Refund dues—prior year .....	.....	75.00	75.00
Contributions—other .....	.....	55.00	55.00
	<hr/> 4,250.00	<hr/> 2,359.66	1,890.34
<b>Office:</b>			
Rent .....	900.00	1,026.28	126.28
Equipment .....	450.00	993.78	543.78
Printing, stationery and postage .....	450.00	756.00	306.00
Telephone and telegraph .....	400.00	322.58	77.42
Miscellaneous .....	150.00	106.50	43.50
	<hr/> 2,350.00	<hr/> 3,205.14	855.14
<b>Travel:</b>			
A.M.A. conference .....	425.00	219.25	205.75
A.M.A. delegate .....	700.00	1,047.74	347.74
Local .....	300.00	377.95	77.95
Guest speakers .....	200.00	100.00	100.00
Contingency .....	200.00	.....	200.00
A.M.A. Public Relations Institute .....	135.00	.....	135.00
	<hr/> 1,960.00	<hr/> 1,744.94	215.06
<b>Annual Session:</b>			
Meals and entertainment .....	\$ 1,100.00	\$ 2,160.00	\$ 1,060.00
Stenotypist .....	350.00	652.50	302.50
Program and tickets .....	300.00	438.30	138.30
Rent of hall .....	300.00	528.60	228.60
Badges .....	70.00	82.97	12.97
Exhibits .....	50.00	474.15	424.15
Miscellaneous .....	45.00	69.00	24.00
	<hr/> 2,215.00	<hr/> 4,405.52	2,190.52
<b>TOTAL EXPENDITURES</b> .....	<hr/> 20,935.00	<hr/> 20,875.15	59.85
<b>EXCESS REVENUE OVER EXPENDITURES</b> .....	<hr/> 565.00	<hr/> 1,434.23	869.23
	<hr/> <hr/> \$21,500.00	<hr/> <hr/> \$22,309.38	\$ 809.38

## Schedule A-1

**GENERAL FUND**  
**Statement of Securities Owned at July 31, 1958**  
**And Income Therefrom During the Year Then Ended**

Face Value or Shares	BONDS	Book Value 8-1-57	Transactions During Year			Book Value 7-31-58	Market Value 7-31-58	Income Received Exhibit B
			Purchases	Sales or Redemption	Gain Loss			
\$7,000	U.S. Savings bonds, series J. dated Oct. 1953, due Oct. 1965	\$ 5,040.00	\$ .....	\$ .....	\$ .....	\$ 5,040.00	\$ 5,523.00	\$ .....
	STOCKS							
33 shs	Bank of Delaware, capital, par \$25.00	1,725.00A	.....	.....	.....	1,725.00	3,085.50	133.50
40 shs	Continental American Life Insurance Co. par \$10.00	1,130.50	.....	.....	.....	1,130.50	2,640.00	62.00
40 shs	E. I. duPont de Nemours & Co., \$4.50 pfd., no par	4,741.03	.....	.....	.....	4,741.03	4,060.00	180.00
7 shs	Farmers Bank of State of Delaware, capital, par \$50.00	2,800.00	.....	.....	.....	2,800.00	4,725.00	210.00
15 shs	Hercules Powder Co., 5% pfd., par \$100.00	1,804.55 12,201.08	.....	.....	.....	1,804.55 12,201.08	16,160.50	660.50
		\$17,241.08	\$ .....	\$ .....	\$ .....	\$17,241.08	\$21,683.50	\$ 660.50

(A) Received 3 shares as 10% stock dividend.

## Schedule B-1

**GENERAL FUND**  
**Reconciliation of Dues and A.M.A. Assessments**  
**For the Seven Months Ended July 31, 1958**

	TOTAL Members	TOTAL Amount	NEW CASTLE Members	NEW CASTLE Amount	SUSSEX Members	SUSSEX Amount	KENT Members	KENT Amount
<b>STATE SOCIETY DUES:</b>								
Dues received (A) .....	361	\$16,967.00	287	\$13,489.00	48	\$ 2,256.00	26	\$ 1,222.00
<b>SUBSCRIPTIONS—</b>								
<b>STATE MEDICAL JOURNAL:</b>								
Subscriptions received .....	361	\$ 1,083.00	287	\$ 861.00	48	\$ 144.00	26	\$ 78.00
Remitted to State Medical Journal .....	353	1,059.00	287	861.00	40	120.00	26	78.00
Difference (B) .....	8	\$ 24.00	—	\$ .....	8	\$ 24.00	—	\$ .....
<b>AMERICAN MEDICAL ASSOCIATION:</b>								
Assessments received .....	357	\$ 8,925.00	285	\$ 7,125.00	46	\$ 1,150.00	26	\$ 650.00
Remitted to A.M.A. ....	354	8,850.00	285	7,125.00	43	1,075.00	26	650.00
Difference (C) .....	3	\$ 75.00	...	\$ .....	3	\$ 75.00	—	\$ .....

(A) 1 member's dues (Sussex County) refunded 8-11-58.  
 (B) 7 subscriptions remitted 8-11-58 and 1 subscription refunded.  
 (C) 2 assessments paid 8-12-58 and 1 assessment refunded.

### REPORT OF THE COMMITTEE ON MEDICAL EDUCATION

The Committee on Medical Education has continued its efforts to bring information on advances in medicine to Delaware physicians in practical form. The series of Seminars on Advances in Medicine begun in 1957 has been continued. On November 21, 1957, the Committee presented a three-hour seminar in the Dover Presbyterian Church on "Factors in the Management of Infections", with the cooperation of the Department of Medicine of the Johns Hopkins University School of Medicine. We were fortunate in obtaining Doctors R. Wagner, L. E. Cluff, and E. W. Hook, who discussed, respectively, viral, staphylococcal, and salmonella infections. This was followed by a Round table discussion and question period, which was apparently well received by those physicians who attended.

Another seminar was held May 22, at the Nanticoke Memorial Hospital, Seaford. At the request of the hospital staff, this dealt with "Practical Aspects of Fluid and Electrolyte Balance". We are indebted to the Chemical Section of the Department of Medicine of the University of Pennsylvania School of Medicine and to Dr. George D. Webster, Jr., for their cooperation in this seminar. We are also indebted to Dr. William B. Cooper, Jr., of Seaford, whose presentation of clinical histories materially contributed to the Practicality of this session.

The Committee is presently planning an eight hour seminar on "Care of the Premature Infant", which will be held in early December at the Alfred I. duPont Institute. This will be a joint undertaking with the Delaware State Board of Health and the Cornell University School of Medicine.

The current rate of fourteen hours of instruction per year in these seminars appears to meet the demand. The Committee is willing and able to increase this if there is any positive evidence of demand for more education. Questionnaires have been circulated after each seminar to assess the informational needs of the medical communities. These have been used as a guide in the planning of future seminars, and by Dr. Baker in his planning of the 1958 Annual Meeting.

Generally speaking, the attendance of the seminars by physicians within the respective counties has been gratifying. It has been disappointing, on the other hand, that relatively few physicians have crossed county lines to attend them. The Committee hopes for an increased attendance by physicians of the various counties of affairs held in other counties.

The Committee remains aware of the problems involved in securing more education without leaving one's practice. It has placed in circulation five audio-visual kits for individual study by physicians of the state. Two of these, a review of radiology and a kit on gynecological lesions, have been borrowed from the University of Utah School of Medicine. The remaining three have been supplied by the Delaware Heart Association and by the American Heart Association, and have dealt with various aspects of heart disease.

While in circulation these kits have served a double purpose. By following them up with questionnaires, we have been able to eliminate the necessity for developing our own pilot kit, for which money was appropriated at the last Annual Meeting to investigate the possibilities of this medium. This has resulted in a saving to the Society of about \$500. It is possible that the Committee will develop one or more teaching kits along these

lines, but we have decided to concentrate our efforts on another project that seems more profitable, and about which we did not know at the time of the submission of our last report.

A good possibility exists that two-way radio conferences, permitting direct conversational question and answer periods with the facilities of medical schools from hospital staff conferences, will be instituted in the Philadelphia area. This type of conference has been proven most convenient and very valuable in upstate New York, where it has been pioneered by the State University of New York School of Medicine in Albany.

The Committee has investigated the potentialities of a program of this type with Dr. Fred Richardson, Executive Secretary of the Hartford Foundation, who has, in turn, consulted with fm station WHYY, Philadelphia's Educational TV & FM Channel, and with the Albany Medical School.

There are many technical factors, including the availability of bandwidths, FCC licensing, and practical range of transmission that have yet to be finally solved. It is our impression however, that the WHYY transmitter is capable of instituting this service, and that a change in FCC regulations now being studied would make these conferences practical. The Committee feels that the advantages of regularly scheduled, "live" two-way conferences with medical school faculty are obvious, and recommends to the House of Delegates that this Committee be empowered to continue its efforts to bring this project to Delaware. The estimated cost per hospital installation is \$750, for which financing may be available from sources outside the state.

The Committee also wishes to express its appreciation to Dr. Richardson for the two trips that he has made to Wilmington to meet with the Committee, and for his interest in our problems.

The Committee has observed some scheduling conflicts among the major medical organizations in this state. It suggests that organizations planning major medical meetings for substantial numbers of physicians inform the County and State Medical Societies of their proposed dates as far in advance as possible. If cooperation is forthcoming in this respect, it will be possible for the State Medical Society to serve as a clearing house for scheduling information. Without cooperation this will obviously be impossible, and the Delaware physician will be penalized. The state society, meanwhile, will find ways of giving more publicity to the meeting dates of which it has knowledge.

Respectfully submitted,  
LEWIS B. FLINN, M.D.  
Chairman

### COMMITTEE ON THE BUDGET

#### RECEIPTS

Dues .....	\$20,000.00
Dinner Tickets .....	925.00
Exhibits .....	700.00
Dividends .....	600.00
Journal's Contribution .....	480.00
AMA Reimbursement .....	85.00
	<hr/>
	\$22,790.00

#### DISBURSEMENTS

Salaries, Executive Sec. ..	\$ 7,000.00
Secretary .....	3,300.00
Social Security Taxes .....	202.50
	<hr/>
	\$10,502.50
	\$10,502.50

## OPERATIONS

Journal Subscriptions .....	\$ 1,300.00
Committee on Public Laws .....	200.00
Committee on Medical Service & Public Relations .....	500.00
Committee on Medicare Adjudication .....	50.00
Committee on A.M.E.F. ....	150.00
Other Committees .....	200.00
Auditor .....	275.00
Miscellaneous .....	200.00
Woman's Auxiliary .....	100.00
	\$ 2,975.00
	\$ 2,975.00

## OFFICE

Rent .....	\$ 1,350.00
Telephone, Telegraph .....	400.00
Printing & Stationery .....	600.00
Miscellaneous .....	150.00
	\$ 2,500.00
	\$ 2,500.00

## TRAVEL

AMA Delegates .....	\$ 500.00
AMA - MSEC Conference .....	200.00
AMA - Public Relations Institute .....	150.00
Guest Speakers .....	300.00
Local .....	300.00
Contingency .....	350.00
	\$ 1,800.00
	\$ 1,800.00

## ANNUAL MEETING

Program & Tickets .....	\$ 300.00
Badges .....	70.00
Stenotyping .....	550.00
Prospectus .....	50.00
Clerical .....	45.00
Janitor .....	50.00
Dinner & Supper .....	1,200.00
	\$ 2,265.00
	\$ 2,265.00

## MEMBERSHIPS &amp; CONTRIBUTIONS

Aces & Deuces (AMA)....	\$ 25.00
Conference of Presidents of State & Medical Societies .....	25.00
Medical Society Executives Assoc. (Exec. Sec'y) .....	10.00
Delaware State Science Fair .....	50.00
	\$ 110.00
	\$ 110.00

Balance For Contingencies .....

\$ 2,637.50

\*Hold over appropriation of \$500 for Committee  
on Education not included

\*\*Estimated six months in present location @ \$75  
per month

Estimated six months in Delaware Academy of  
Medicine @ estimated \$150 per month

Respectfully submitted,  
CHAS. LEVY, M.D.

## REPORT OF THE EDITOR

During the past 12 months interest has waned  
in the Journal. Hospitals are submitting material  
inadequate in amount. With few exceptions, all  
material has been submitted late. With few exceptions,  
members of the Editorial Advisory Board  
have shown no interest in the Journal. The re-  
commendation was therefore made to the Publi-  
cations Committee that the Editorial Advisory

Board be abolished. This was passed by the Publi-  
cations Committee.

The services of an expert medical copy-rewriter  
have been obtained. If material is submitted on  
schedule, these services will enable the material to  
be put into shape to enable us to have an out-  
standing journal. We cannot do anything, how-  
ever, when material is submitted one month after  
the deadline.

Respectfully submitted,  
A. H. CLAGETT, JR.  
Editor

## COMMITTEE ON PUBLIC LAWS

The Committee on Public Laws has concerned  
itself with the following subjects during the past  
year:

## THE FORAND BILL

This Bill-HR 9467 — was to provide government  
hospital and surgical care for about 13,000,000  
social security claimants by amending the social  
security act. To supplement the other approaches  
in Delaware calculated to express medicine's op-  
position to this Bill, the members of the Commit-  
tee on Public Laws contacted the director and the  
members of the lay boards of all the hospitals in  
the state urging the lay members of these boards  
to officially contact our representatives in the  
Congress stating the reasons why hospitals them-  
selves are opposed to the principles incorporated  
in this Bill. In addition, representatives of the  
Society called upon Senators Williams and Frear  
and Representative Haskell in their Washington  
offices, in company with state senator John Long-  
botham of the State Labor Commission. The Com-  
mittee is grateful to Messrs. Williams, Frear, and  
Haskell for their promised cooperation, and to  
Senator Longbotham for his help in analysing the  
impact of the Forand bill in Delaware and contrib-  
uting this information to our efforts.

## MEDICAL-OPTOMETRIC RELATIONS

Subsequent to the Supreme Court of Delaware  
confirming a decision of the Court of Chancery  
that Civil Court in this state has no jurisdiction in  
the enforcement of the optometric code, Senate  
Bill 274 was introduced and subsequently passed  
by the State Senate. The purpose of this was to  
extend the jurisdiction of the Court of Chancery  
to include enforcement of the optometric code and  
to provide the Board of Optometric Examiners  
with the right to apply for such relief as deemed  
necessary, without penalty and at state expense.  
This legislation was vigorously opposed in the  
House for reasons stated in a letter to the Repub-  
lican caucus of the General Assembly signed by  
John B. Baker, M.D., President of the State So-  
ciety. Information furnished Representative H.  
Clifford Clark was kindly presented by him to the  
Democratic caucus with obvious success. In addi-  
tion, cooperation was obtained through the Dela-  
ware State Bar Association in the preparation of  
a substitute bill which was to replace Senate Bill  
274 in the event that the bill could not be kept in  
committee. The purpose of the substitute bill was  
to give all professions the same recourse in the  
Court of Chancery as 274 asked for optometrists  
alone. The subsequent failure of Senate Bill 274  
to come before the House, however, made it un-  
necessary to submit the substitute bill during this  
session of the legislature.

The Committee on Public Laws submitted in a  
separate communication to the Council a detailed

analysis of the stand which medicine should take in the current suit between the Delaware State Board of Examiners of Optometry and Edwin Kuhwald, optician. The essence of this recommendation was that while it was felt that the medical society should avoid active participation in the suit, from the point of view of legal entanglements, every possible effort should be made to show the Court and the public medicine's unmistakable position in regard to the utilization of technical aides and the unacceptance by medicine of any legal limitation on medicine by fringe practitioners.

To pursue this purpose, the Committee requests the House of Delegates' authorization for the following course:

1. That the state society *not* ask the Court's permission to enter this case directly.
2. That the Society, through the Committee on Public Laws, offer the defense counsel every assistance in the preparation of his case.
3. That to implement paragraph 2 above, the Committee be authorized to provide such expert witnesses as may seem advisable, and, if necessary, assist in the financing of these appearances subject to the approval of the Council in specific instances.

#### PROPOSED CHANGES IN THE MEDICAL PRACTICE ACT

The Committee on Public Laws was instructed by Dr. Baker to meet with the Medical Practice Act, which apparently Judge Terry and Dr. Washburn thought needed changing. My latest report from Dr. Wallace Johnson, a member of the Medical Council, is that Judge Terry is not yet ready to make a recommendation in this connection. It is impossible, therefore, for the Committee on Public Laws to make a report and recommendation to the Council of the Society on this topic.

#### FUTURE LEGISLATION

A belated and unsuccessful attempt was made to have included in the platform of the major political parties in Delaware the abolition of the office of the coroner in this state. The Committee did support, against overwhelming pressure, Senator McCullough's bill to eliminate the office. We were not successful in securing its passage.

The Committee has deferred action this year on its proposed bills defining the place of the aide in medical practice and raising the standards of scientific education for all licenses to heal. Private conferences with their friends in the General Assembly have convinced us that these bills might survive either the Legislature's preoccupation with the state's financial problems or the pressure of the optometry group, but not both. It has seemed wiser not to enter a fight that we probably would not win, but to defer action until the state's budget crisis is less acute.

The Committee has enjoyed support from both sides of the State House of Representatives, and is grateful to those who have helped. We especially commend Mr. H. Clifford Clark of Kenton and Mrs. Margaret R. Manning of Wilmington, members of the House Committee on Public Health, for their interest in the public welfare.

Respectfully submitted,  
**WILLIAM O. LAMOTTE, M.D.**  
*Chairman*

#### REPORT OF THE MANAGING EDITOR AND BUSINESS MANAGER

Conclusion of operations, July, 1957, Issue to  
 Conclusion of operations, July 1958, Issue

##### A. CHECKING ACCOUNT

Balance in Checking Account at conclusion of operations, July, 1957, \$ 5,837.62  
 Issue.

##### RECEIPTS

Advertising	\$24,121.56
Subscriptions	1,339.54
Single Copy Sales	19.76
Royalties	.53
Roster Sales	16.00
SMJAB-Share Profits	707.01
Interest	87.50
*Reimbursed conference expense 211.76 (see below)	
	\$26,503.66

##### DISBURSEMENTS

Printing and Mailing Journal	\$17,901.44
Salaries, Excluding Taxes withheld	3,484.60
Taxes, including Taxes withheld	339.30
Addressing of Journal	120.00
Copyrights	48.00
Rights, Medical Cartoons	100.00
Special printing (Indices & Inserts)	187.18
Plates	77.34
Insurance	92.85
Stationery & Supplies	102.45
Editing of Seminar Transcript	65.00
Legal Column	75.00
Postage Account	10.00
*Conference Expense (Reimbursed-see above)	211.76
	22,814.92

Balance After Operations, July, 1958, Issue	9,526.36
Balance in Account Conclusion of Operations, July, 1958, Issue	9,526.36

Profit from Operations \$ 3,688.74

##### B. SAVINGS ACCOUNTS

Wilmington Savings Fund Society	
Balance, August 1, 1957	\$ 3,626.53
Interest	117.84
Balance, August 1, 1958	3,744.37
Wilmington Trust Company	
Balance, August 1, 1957	\$ 1,748.06
Interest	17.48
Balance, August 1, 1958	1,765.54

Balance in Savings Accounts \$ 5,509.91

##### C. WAR BONDS

U. S. War Bonds, Purchased Dec. 10, 1942 @ \$ 3,502.38	
Balance, August 1, 1958	\$ 3,502.38
Total, Accounts A, B, and C	\$18,538.65

Respectfully submitted,  
**M. A. TARUMIANZ, M.D.**  
*Managing Editor*  
**LAWRENCE C. MORRIS, JR.**  
*Business Manager*

WOMAN'S AUXILIARY TO THE  
MEDICAL SOCIETY OF DELAWARE  
REPORT OF THE PRESIDENT  
1957-1958

The year 1957-58 has been a busy one and, I feel, a fruitful one for the Woman's Auxiliary to the Medical Society of Delaware. Upon returning from the planning conference in October 1957, I forwarded to each county president the directives as received from the National Auxiliary to the American Medical Association. They were centered around the theme, "Health is a joint endeavor." We were requested to emphasize recruitment in all medically related fields, assist in the AMEF program, continue our efforts with the distribution of TODAY'S HEALTH, and cooperate with mental health and safety agencies. We were also asked to keep informed on all legislature pertinent to the medical profession. That these objectives received the full support of our three county auxiliaries is evidenced by the reports of the county presidents and of the state chairman.

The recruitment committee, by contacting all state high schools including parochial and private, received 27 applications for nurses' scholarships, four from Kent, nine from Sussex, and thirteen from New Castle. Seven students were awarded \$150 each. Applications were also processed in behalf of the Wilmington Rotary Club, who awarded nine scholarships of \$350 each. This brings the number of scholarships awarded by the auxiliary since the project began in 1950 to a total of 29. We feel that in addition to benefiting the students and the medical profession our scholarship program is good public relations at work.

We are especially pleased with the gain in our AMEF aid. In May our state chairman forwarded to the national office a check for \$677.05. This represents a gain of \$253.00 over the previous year, causing us to rank eleventh in the national list with an average of over three dollars per member. We feel that progress has been made, not only in a monetary sense, but also in creating an awareness of the need for such auxiliary participation in the AMEF program.

The chairman of TODAY'S HEALTH and her committee have worked most diligently to obtain ninety-one (91) subscriptions. Inasmuch as this magazine is published by the American Medical Association and depends to a large extent upon the medical auxiliaries for its distribution, the Delaware Auxiliary has place in its minutes a recommendation that each member be billed for a one year subscription when billed for annual dues.

Several projects pertaining to mental health have received the ardent interest and assistance of our auxiliary members. The re-activating of the library at the Delaware State Hospital was one such project. This necessitated many hours of work collecting and cataloguing books. The members also assisted with the annual fair given for the patients at the State Hospital and gifts at holiday times were solicited for the children at Stockley by the auxiliary members in the lower counties. Several of our auxiliary members are on the active volunteer staff of the Mental Health Agency and have assisted to a great extent in the Agency's educational program.

The state legislative chairman has forwarded to the county auxiliaries all national communiques about the pending bills relative to the medical profession in order that we might have an informed membership. Mr. Harry Haskell, Delaware's Congressional Representative, was written

on both a county and a state level concerning our opposition to the Forand Bill.

In conjunction with our recruitment program the auxiliary cooperates with Delaware League of Nursing in stimulating interest among the high school students. This is done mostly by the creating of future nurses' clubs. Teas, field trips, speakers for meetings, and transportation have been provided by auxiliary members when needed. This year added emphasis has been given to these high school students on the possibility of laboratory work.

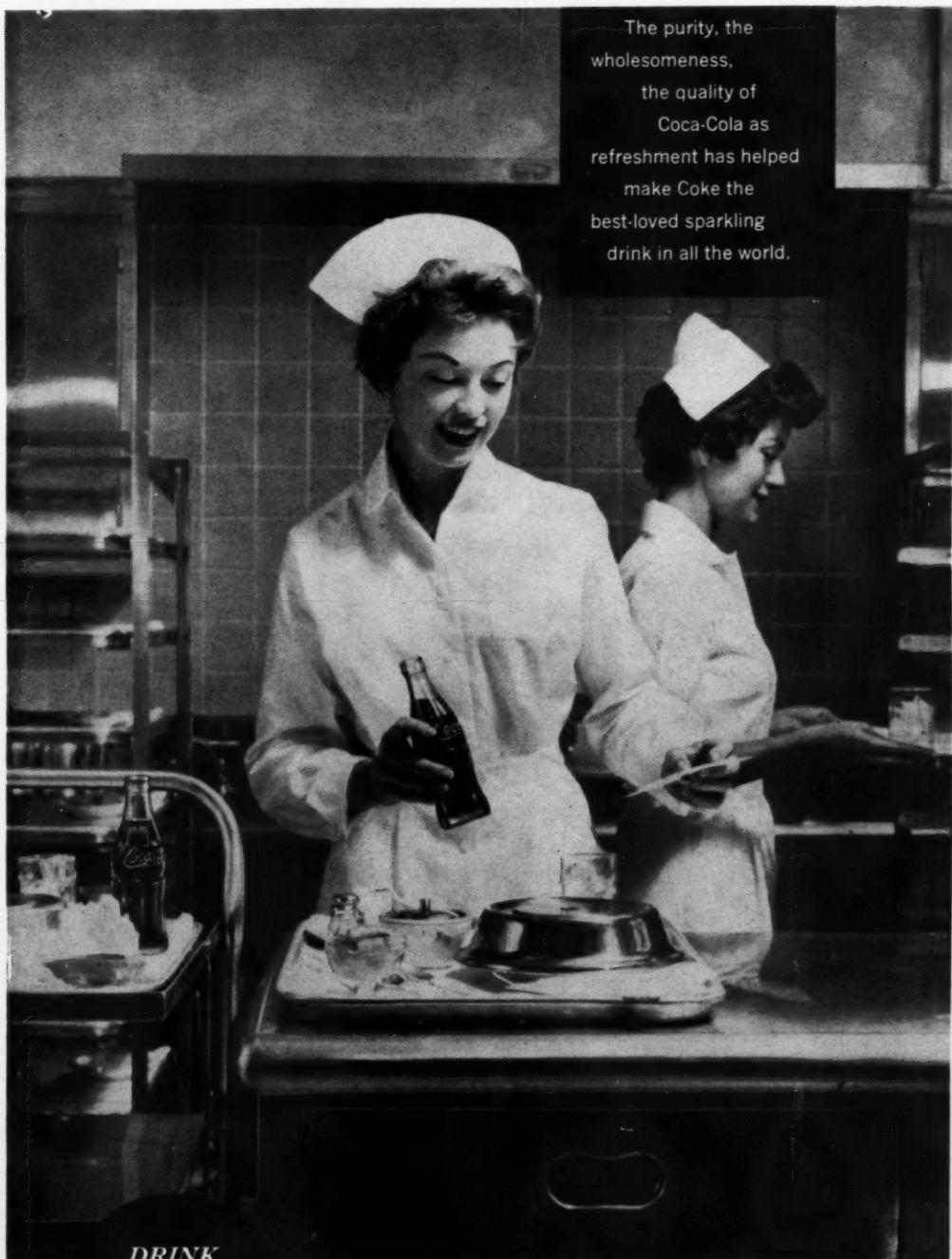
Our membership remains the same as last year, 280 paid members. This is not due to the fact that no new members have been added, but because inactive members have been dropped. Our three counties are completely organized and hold regular meetings. We are also pleased to report that new chairmanships have been added which now enables all county units to function according to national auxiliary directives.

In order to ascertain the interests and activities of our members, the public relations chairman and her committee developed a questionnaire that was sent to all members. The response was most gratifying. When the data was compiled it was found that our membership serves the community in many ways: through Scouting, P. T. A., church organizations, hospital boards, community drives, Red Cross, civil defense, medical auxiliary, and citizen political forums. The amount of time devoted by the Delaware doctor's wife working towards the betterment of her community averages one hundred and fifty hours per year. This compilation was reported along with a regular meeting notice by our publicity chairman to the local newspapers and thus we hope another step forward in good public relations was taken.

Civil defense and safety, in the home and on the highway, both received consideration in our program during the year through the distribution of literature, speakers at our meetings, and the showing of films.

During the past year I presided at three state executive board meetings. I attended several New Castle County Auxiliary meetings and was a guest at a meeting in Sussex county. Approximately 12,500 miles were covered on my trips to the Chicago Planning Conference and to the San Francisco meeting of the American Medical Association. In addition to these trips, I represented Delaware at the New Jersey, New York, and Maryland State Meetings. I have answered all personal correspondence relative to the office of president, and have written two articles for the National Bulletin and one for the Delaware State Medical Journal. In addition to these writings I compiled and forwarded the triplicate twenty page chairman reports, and the five hundred and eight hundred presidential reports required by the National Auxiliary this year, and I gave the oral report at the National Meeting in San Francisco.

During the twenty-nine years that the Woman's Auxiliary to the Medical Society of Delaware has been in existence there have been many accomplishments and much growth. The main objective has been to assist in our capacity as doctors' wives the Medical Society of Delaware in its program for the advancement of medicine and public health. The prospect for future advancement and development of this objective by the Auxiliary is indeed bright, however, such progress can only be made by the efforts of each county auxiliary and by each constituent member.



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Doctors are generally agreed that the best hope of saving lives from cancer is early detection and prompt, proper treatment. Great progress has been made in the last ten years: the saving now of 1 in 3 compared with 1 in 4, as more and more people are seeing their doctors **in time**.

But with present knowledge and existing facilities, it is possible **today** to save **1 in 2** cancer patients. This is the target of the American Cancer Society's professional and public education programs.

The Society offers doctors a variety of free services: **Literature**: two bi-monthly magazines; **Films**: 200 available on loan, including a series of kinescope films covering practically every clinical phase of cancer; **Slides**: (In color) Characteristic early lesions in sites of greatest incidence; **Exhibits**: for medical meetings and conventions, on special aspects of diagnostic and therapeutic problems.

In its public education program, the Society uses every effective communication medium to urge people to have annual health checkups and to go to their doctors promptly at the appearance of a danger signal.

The challenge will be met. As more and more doctors' offices become "cancer detection centers," and as more and more people see their physicians regularly, the closer will come the day when half of our cancer patients will be saved. The knowledge for saving the remaining half is still being sought in our research laboratories. Ultimately that challenge, too, will be met.



**DELAWARE DIVISION, AMERICAN CANCER SOCIETY**

**1324 Market Street, Wilmington**

It has been my privilege to serve as the seventeenth president of the Woman's Auxiliary to the Delaware Medical Society and my tenure of office has been possible only by the cooperation of my executive board and by the moral support tendered to me by my understanding family. To them I express my deepest appreciation.

Respectfully submitted,  
HESTER S. THOMAS (MRS. ROGER B.)

**COMMITTEE ON ADVISORY TO WOMAN'S  
AUXILIARY  
MEDICAL SOCIETY OF DELAWARE**

As a group this committee, as in previous years, has been called upon in only several instances. The transportation and housing facilities of the Delaware Medical Auxiliary delegate to the National Auxiliary of the American Medical Association which was held in San Francisco were arranged for and checked. Financial and moral support, and frequent oral advice seemed to be the main order of this committee.

Inasmuch as the Delaware State Medical Auxiliary depends upon yearly dues of one dollar (\$1.00) per member to cover operating expenses of the organization, this committee recommends that a one hundred (\$100.00) yearly stipend be given by the Medical Society of Delaware to the Woman's Auxiliary to assist in operating expenses.

It has been a pleasure working with the Woman's Auxiliary and the members of this committee.

Respectfully submitted,  
ROGER B. THOMAS, M.D.  
Chairman

**REPORT OF THE COMMITTEE ON  
ALCOHOLISM  
MEDICAL SOCIETY OF DELAWARE**

In Delaware four public institutions care for and treat alcoholics, namely the facilities of the State Board of Corrections, the Delaware State Hospital, the State Welfare Home and Hospital for the Chronically Ill, and the Governor Bacon Health Center. The State Board of Corrections is involved with alcoholic persons who transgress the laws of the State and Nation. The Delaware State Hospital treats alcoholics who are psychotic or too seriously disturbed emotionally to remain in the community. The Mental Hygiene Clinics of the State of Delaware provide outpatient treatment for alcoholic patients. The State Welfare Home and Hospital for the Chronically Ill gives residential care and treatment to alcoholics who are indigent or who otherwise qualify for the services of this institution. The Governor Bacon Health Center through its Alcoholic Rehabilitation Unit makes available residential care and treatment for alcoholics without frank psychosis.

This report presents data concerning alcoholics treated in Delaware during the fiscal year 1957-58 at three state institutions. The data from the State Welfare Home and Hospital for the Chronically Ill are for the calendar year, January 1 to December 31, 1957.

**THE BOARD OF CORRECTIONS, STATE OF DELAWARE**

During the fiscal year 1957-58 the Board of Corrections for the State of Delaware made a total of 2,098 commitments on the charge of Drunk and Disorderly. This total represents commitments of 1,963 males and 135 females. There was a total of 633 commitments on the charge of "Driving

Drunk." Committed on this charge were 618 males, 15 females. The number of inmates who participated in the alcoholic treatment program at Delcastle Farms was 139. Information is not available on the number of persons involved in the over-all total of 2,731 commitments on the two specific charges relating to the use of alcohol. It is estimated that some 500 persons were convicted of these charges, some being committed repeatedly. Although data is not readily available from the Board of Corrections on the number of commitments in which the use of alcohol was a contributory factor in other misdemeanors and felonies, newspaper reports and other sources indicate that alcoholism is frequently a factor in crime and delinquency.

**DELAWARE STATE HOSPITAL**

The Delaware State Hospital at Farnhurst, Delaware, during the fiscal year 1957-58 received as first admissions to a psychiatric hospital 40 alcoholic patients who suffered from psychosis (32 males, 8 females.) Ten patients (5 males, 5 females) readmitted to the State Hospital were alcoholics. The total number of alcoholic patient admissions for the past fiscal year was 50 (37 males, 13 females). None of these patients was committed to the Hospital by a court.

In the past fiscal year 49 alcoholic patients (33 males, 16 females) returned to the community on trial visit. Fifty-five alcoholics (48 males, 7 females) were discharged during the fiscal year. One alcoholic patient died in the Hospital during the past year, a 63 year old male whose death was caused by bronchial pneumonia. The statistics for alcoholic patients who left on trial visit or were discharged during the fiscal year include patients admitted to the Hospital in prior years as well as some admitted during 1957-58. At the end of the fiscal year 53 alcoholic patients (44 males, 9 females) remained in residence.

The ages of the alcoholic patients admitted and readmitted to the Delaware State Hospital in 1957-58 ranged from 26 to over 65 years. The greatest number of first admissions and readmissions occurred between the ages 36 to 50, 62 per cent of the total alcoholic admissions falling in this age bracket.

**MENTAL HYGIENE CLINICS**

During 1957-58 the Mental Hygiene Clinics of the State of Delaware admitted for treatment 15 alcoholics (13 males, 2 females). These patients ranged in age from 22 to 59 years with 9 of them between 30 and 45 years of age. Of these patients 9 (8 males, 1 female) were discharged during the fiscal year. Six of them (5 males, 1 female) were still in treatment at the end of the fiscal year.

**THE STATE WELFARE HOME AND HOSPITAL FOR THE  
CHRONICALLY ILL**

The State Welfare Home and Hospital for the Chronically Ill, at Smyrna, Delaware, each year admits a small number of patients diagnosed as alcoholics. During the calendar year (January 1-December 31, 1957) 17 alcoholics (15 males and 2 females) were admitted for care and treatment at this institution. Six of these patients were discharged during the year, three died. Eight remained in residence at the end of the calendar year.

**THE GOVERNOR BACON HEALTH CENTER**

The Governor Bacon Health Center, at Delaware City, Delaware, during the fiscal year 1957-

58, received as first admissions 89 alcoholic patients (72 males, 17 females). During the period being studied there were 65 readmissions (57 males, 8 females). The total number of admissions and readmissions of alcoholic patients in the Alcoholic Rehabilitation Unit was 154 (129 males, 25 females).

During the fiscal year 159 alcoholic patients (135 males, 24 females) were discharged. Two alcoholic patients (aged 54 and 59 respectively) died during the year. The former died of lobar pneumonia, micro abscesses of the liver, cerebral congestion, and edema. The latter patient's death was caused by cardiac asthma, with chronic alcoholism a contributory cause. At the end of the fiscal year 28 alcoholic patients remained in treatment. Of this number 24 were males, 4 were females.

The fiscal year 1957-58 marked the tenth year of the operation of the Governor Bacon Health Center. Provision for the treatment of "men and women of all ages who suffer from alcoholism or who are drug addicts and who are without frank psychosis, either acute or chronic" was included in the legislative action establishing the Health Center. (Delaware Code Annotated, Title 16, Chapter 53, Subchapter 1, Paragraph 5304.) Since its inception to the close of the fiscal year 1957-58 a total of 1,298 patients (1,141 males, 158 females) have been received as first admissions for treatment of alcoholism. In the same period there have been 796 readmissions (732 males, 64 females) readmitted for treatment of chronic alcoholism.

#### CONCLUSION

From the above facts it is obvious that the problem of alcohol still remains a serious one in the State of Delaware. Possibly education should be considered the first step in the program to alleviate the problem. The second step would be more intelligent and more effective utilization of the preventive and treatment facilities in the State. For this the cooperation of physicians, members of the Judiciary, clergy, educators, families is necessary. Persons whose drinking has become excessive or otherwise abnormal, should be referred at once for outpatient or residential treatment. Too often the aberrant drinking behavior is ignored or at least not given serious attention until the habit has become extremely serious or until the person becomes involved with the police. Intensive treatment when a person given the first indication of becoming a problem drinker undoubtedly would do much to prevent the waste in manpower potential, the suffering and even the tragedy which may result from alcoholism.

M. A. TARUMIANZ, M.D.  
*Chairman*  
H. T. McGuire, M.D.  
C. J. PRICKETT, M.D.  
BRUCE BARNES, M.D.

#### COMMITTEE ON AMERICAN MEDICAL EDUCATION FOUNDATION 1958

The Committee on the American Medical Education Foundation reports contributions of \$2757.50 for the period January 1, 1958 through August 31, 1958. In accordance with the recommendation of the House of Delegates, expressed at its 1957 meeting, the Committee solicited funds early in 1958. In view of the mediocre response to date, we shall send another mailing before the end of the year.

After careful consideration, the Committee has decided to solicit funds by mail only. While we

realize that this is possibly less productive to the A.M.E.F., we feel that it definitely is more acceptable to the membership of the Society.

The Chairman visited Chicago in February of 1958 to attend the Annual Meeting and Conference of Chairmen of the A.M.E.F. All of the expenses of this trip were borne by the AMA. 100% of the funds donated to the A.M.E.F. continue to be forwarded to the medical schools.

The Committee wishes to express its appreciation to the Central office of the A.M.E.F. for its cooperation and help in supplying literature and advice whenever called upon.

Respectfully submitted,  
J. L. FOX, M.D., *Chairman*  
J. J. DAVOLOS, M.D.  
F. R. EVERETT, M.D.  
J. R. KERRIGAN, M.D.  
R. L. KLINGEL, M.D.  
W. W. LATOMUS, M.D.  
F. O. POOLE, M.D.  
S. W. RENNIE, M.D.

#### REPORT OF COMMITTEE ON DIABETES

The activities of the Committee on Diabetes of the Medical Society of Delaware have been largely involved in assisting members of the American Diabetes Association in Delaware in establishing an affiliate of the A. D. A. In the June meeting of the American Diabetes Association in San Francisco, the Delaware Diabetes Association was approved and is now in being. There are thirteen charter members. It is hoped that there soon will be a larger Delaware membership and that, with this association as a basis for diabetic activities throughout the entire state, cooperating with the Medical Society of Delaware and the Public Health Service, that subsidiary associations of lay diabetic societies will presently be performed. By such means education in diabetes will be carried on both through professional channels and through friends of diabetics and the public generally. Such a program should react to the benefit of all concerned, and certainly is in line with the policies of the Education Committee of the State Society.

Since at the present time, the Delaware Diabetes Association is without funds and since it is important to carry on diabetes detection this coming November, and in line with previous actions of the Medical Society of Delaware, the Committee requests immediate appropriation not to exceed \$100 for this educational activity for the current year. Diabetes week this year is November 16 to 22.

Respectfully submitted,  
LEWIS B. FLINN, M.D., *Chairman*

#### COMMITTEE ON GRIEVANCE BOARD MEDICAL SOCIETY OF DELAWARE

Mr. President and Members of the House of Delegates:

Your Grievance Board has had nothing to do this year. There have been no cases referred directly to it and none referred from either one of the County Societies.

We hope in this case that no news is good news.

Respectfully submitted,  
E. R. MAYERBERG, *Chairman*  
BRUCE BARNES  
ROGER MURRAY  
H. W. SMITH  
M. A. TARUMIANZ

### REPORT OF COMMITTEE ON MATERNAL AND FETAL MORTALITY

During the year 1957 the total number of live births increased from 11,242 in 1956 to 11,844. There were four maternal deaths. (A maternal death is defined as: The death of any woman dying of any cause whatsoever while pregnant or within 90 days of the termination of the pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it was terminated.) This definition has been used in arriving at our statistics and is being used thru out the country by State Committees on maternal and infant mortality.

Therefore please mention pregnancy under "other significant conditions" when completing a death certificate on any female if such condition has existed within a period of 90 days of death regardless of cause of death.

The four maternal deaths in 1957 shall be designated as A, B, C, and D.

Case A: Age 35, Classified: Direct obstetric non-preventable. Factors of responsibility are assigned to patient herself and her family. This patient had septic miscarriage and died of septicimia following miscarriage. Patient did not present herself for treatment until too late.

Case B: Age 41, Classified: Direct obstetric non-preventable. Gravida XVI weight 300 pounds. Patient died of spontaneous rupture of uterus during normal labor. Catastrophic accident. Patient expired despite heroic measures. This is a hemorrhagic death.

Case C: Age 43, Information incomplete at this time.

Case D: Age 31, Classified: Direct obstetric non-preventable, Gravida IX, para VII, weight 275 pounds. This patient died of cardio-vascular collapse due to blood loss and septic incomplete abortion.

Most frequent causes of maternal death in Delaware as elsewhere are hemorrhage and infection. We must continue our vigilance against the most frequent causes of maternal deaths as they exist throughout the United States. i.e. 1—Hemorrhage 2—Infection, 3—Toxemia, 4—Anesthesia.

#### Recommendation:

I Continued careful natal care.

II One source of bleeding during delivery which can be greatly decreased, is that occurring during the fourth stage of labor. More attention must be given to uterine care to prevent relaxation and subsequent bleeding.

III To prevent possible aspiration during obstetric anesthesia maternity patients should be instructed to avoid all solid foods once labor begins.

Respectfully submitted,  
F. S. HASSSLER, M.D., Chairman

### REPORT ON INFANT MORTALITY—1957

The committee on Maternal and Infant Mortality has continued to study the causes of death of those infants who died within the first seven days of life. During 1957, 11,844 babies were born, and 177 of them expired in the first week, giving

a rate of 14.9/1000 live births. This is comparable to 14.4 in 1955 and 14.5 in 1956.

#### STUDY SOURCES

The hospital charts of the infants and their mothers were reviewed and a form similar to that used in Philadelphia was filled in by members of the committee. This material is summarized in Tables I and II.

#### COMMENTS

When the statistics listed in Tables I and II are compared to those of last year, there is little significant change. The Delaware Hospital is the only hospital that has continued a steady downward trend in the rate of deaths in the first seven days of life. If only the viable babies, those weighing more than 1000 Gms. are considered, the Kent General Hospital and the Milford Memorial Hospital have consistently reduced their rates. None of these are statistically valid reductions, however.

The rise in the rate in home deliveries is interesting. In 1954, there were 507 home deliveries, compared to 253 in 1957. The total number of births in Delaware increased from 9,736 in 1954 to 11,844 in 1957. In 1954 there were four deaths, for a rate of 7.9/1000 L.B., and in 1957 there were ten deaths, for a rate of 39.5/1000 L.B. This higher death rate would seem to infer that home deliveries are not done as well as they were a few years ago. This may be true, but a more detailed perusal of the cases shows a striking lack in prenatal care. Of the ten patients in 1957, seven had no prenatal care, two had begun prenatal care within a month of delivery, and we have no information about the tenth. Eight of these persons were colored. Only one of the deliveries was done by a mid-wife. The rest were delivered at home by the family or in an automobile on the way to the hospital.

Inadequate or complete lack of prenatal care was a factor involved in 36 of the 177 deaths, about 20%.

#### RECOMMENDATIONS

1. That a campaign be started to call attention to the importance of early and regular prenatal care. The State Board of Health should be consulted in this regard.

2. Beginning with January 1958, a form has been sent to the physician responsible for babies who died within the first seven days of life. The doctor is requested to fill in the information and return the form to the Delaware Medical Society office. It has been suggested that the forms be made available at each of the hospitals so that the doctor can fill in the information at the time of the death and send it to the medical society. If this form is not received by the medical society within two months, another form will be mailed directly to the physician.

3. One member of this committee attended a regional Conference on Pre-natal Mortality and Morbidity Problems, held by the A.M.A. Committee on Maternal and Child Care. An outline of the Delaware neonatal mortality study was used as an example of a state-wide program in the background material distributed prior to this conference. Many facets of these problems were discussed—varying from basic research to the mechanics of collecting statistical data. The problem of whether or not the collection of data should be standardized, so that studies in various commun-

TABLE I

	Delaware	Wilmington General	Memorial	St. Francis	Riverside	Kent General	Milford Memorial	Beebe	Nanticoke	U.S.A.F. Dover	Home	Total
Total live births	2993	2245	1790	907	180	1187	974	388	480	447	253	11,844
Deaths in 1st 7 days	36	45	28	13	5	9	18	8	9	3	3	177
Corrected deaths in 1st 7 days	34	41	27	13	6	10	17	7	9	3	10	177
Deaths/1000 L.B. in 1st 7 days	11.4	17.8	15.1	14.3	33.3	8.4	17.4	18.1	18.8	6.7	39.5	14.9
Deaths/1000 L.B. in 1st 24 hrs.	7.3	13.4	9.5	12.1	26.8	6.7	14.4	7.7	8.3	6.7	39.5	10.1
Deaths in 1st 7 da. wt. over 1000 Gms.	27	34	15	7	2	6	8	4	7	2	4	116
Deaths/1000 L.B. 1st 7 days wt. over 1000 Gms.	9.0	15.1	8.4	7.7	11.1	5.1	8.2	10.3	14.6	4.5	15.8	9.8
% preventable	25	24.4	44.4	46.2	60	33.3	53	42.8	22.3	33.3	50	
500-1000 Gms.	44.5	57.8	44.4	38.4	20	44.4	35.3	57.2	44.4	33.3	37.5	
% viable prematures	30.5	17.8	11.2	15.4	20	22.3	11.7	0	33.3	33.4	12.5	
1000-2500 Gms.												
% full term over 2500 Gms.												

Corrections: Delaware—Minus 1—Transferred from Kent General—expired a few minutes after arrival  
 Minus 1—Transferred from Riverside—difficult delivery—intraventricular hemorrhage

Wilmington General—Minus 4—Delivered at home

Memorial—Minus 1—Delivered on way to hospital

Milford Memorial—Minus 1—Delivered on way to hospital

Beebe—Minus 1—Delivered at home by mid-wife

TABLE II

	Delaware	Wilmington General	Memorial	St. Francis	Riverside	Kent General	Milford Memorial	Beebe	Nanticoke	U.S.A.F. Dover	Home	Total
Undetermined	16	22	15	7	1	5	11	5	5	2	3	92
Hyaline Membrane	2	7	6	2								18
Congenital Anomaly	7	4	3	1								22
Intrauterine Anoxia	5	3	3	2	3	1	3	1	1	1		22
Intracranial Hemorrhage	3	4					2	2	1			12
Erythroblastosis		2		1								3
Adrenal Hemorrhage						1						1
Intrapulmonary Hemorrhage	1		1									2
Bronchopneumonia	1	1										2
Aspiration Pneumonia	1											2
Sepsis-Shigella	1											1
Total	36	45	28	13	5	9	18	8	9	3	3	177
% Undetermined	44.5	48.9	53.6	53.8	20	55.6	55.6	62.5	55.6	66.7	100	
Autopsies	20	22	12	4	1	7	5	2	6	1	0	80
% Autopsies	55.6	48.9	42.8	30.8	20	77.7	27.8	25	66.7	33.3	0	45.2

ties can be compared was not solved, but the general opinion was that comparison of one hospital or community with another is not the basic purpose. The main objective is to get each hospital group and each individual doctor to examine the causes for the deaths to determine specific needs for improvement in obstetrical and pediatric care. The members of this committee hope that this annual report may be a stimulus for reviewing techniques, equipment and nursing care.

4. With little added effort, since the mechanics of collecting information have been fairly well worked out, this study could be extended to include all deaths occurring within the first 28 days of life.

#### SUMMARY

The 177 infant deaths which occurred during the first seven days of life have been reviewed. The preventable deaths were discussed and comments made concerning the statistical data. Recommendations were made.

#### REPORT OF COMMITTEE ON MEDICO-LEGAL AFFAIRS

The Committee on Medico-Legal Affairs, together with its counterpart from the Delaware Bar Association, presented the Third Annual Medico-Legal Symposium at the Alfred I. duPont

Institute on Sunday, April 27, 1958. The facilities of the Institute were made available to the combined Committee through the courtesy of Mrs. Alfred I. duPont and Alfred R. Shands, Jr., M.D., Director of the Alfred I. Institute.

Co-chairmen of the meeting were the Honorable Daniel L. Herrmann, chairman of the Medico-Legal Committee of the Delaware Bar Association and Philip D. Gordy, M.D., chairman of the Medico-Legal Committee of the Delaware State Medical Society.

The group was welcomed by Dr. Alfred R. Shands, Jr., Director of the Alfred I. duPont Institute; and opening remarks were then presented by H. Albert Young, Esq., President, Delaware Bar Association, and John B. Baker, M.D., President of the Medical Society of Delaware.

The Honorable Charles L. Terry, Jr., President Judge of the Superior Court of the state of Delaware, then presented an address on "The Doctor Witness."

A trial tactics demonstration was then presented with a presentation centering around a case of whiplash injury. A team of experts from New York City presented this demonstration.

The afternoon program consisted of the film, "The Doctor Defendant" following which, a panel and floor discussion took place moderated by James T. Metzger, M.D.

It was felt that the Third Annual Medico-Legal Symposium had been eminently successful in again bringing together the medical and legal professions over problems of mutual interest and importance. The present plans are for continuation of the Symposia on an annual basis.

A review of the financial picture revealed a balance from the previous seminar of \$170.97, total disbursements for the 1958 Symposium were \$610.22 receipts from the Symposium were \$572.75 leaving a balance of \$133.50 as a cash balance.

The Committee wishes to thank all of those whose efforts resulted in the eminently successful Third Annual Medico-Legal Symposium.

Respectfully submitted,  
PHILIP D. GORDY, M.D., Chairman  
September 24, 1958

Joint Committee on Medico Legal Affairs  
of the Medical Society of Delaware  
and The Delaware Bar Association  
Wilmington, Delaware

Gentlemen:

We have examined the cash records of the Joint Committee on Medico-Legal Affairs of the Medical Society of Delaware and the Delaware Bar Association for the period June 1, 1957 to May 31, 1958.

Recorded receipts were traced to deposits in bank and canceled checks were compared with check stubs. Cash in bank at May 31, 1958 was confirmed direct to us by the Farmers Bank and was reconciled with the checkbook balance at that date.

In our opinion, premised on the scope of this examination, the attached statement presents fairly the cash position of the Joint Committee on Medico-Legal Affairs of the Medical Society of Delaware and the Delaware Bar Association at May 31, 1958 and the results of its cash transactions for the period indicated.

Very truly yours,  
HAGGERTY & HAGGERTY  
Certified Public Accountants

#### JOINT COMMITTEE ON MEDICO-LEGAL AFFAIRS

Statement of Cash Receipts and Disbursements	
For the Period June 1, 1957 to May 31, 1958	
Balance, June 1, 1957.....	\$170.97
RECEIPTS:	
Legal symposium .....	572.75
	572.75
DISBURSEMENTS:	
Luncheon .....	\$295.00
Guest speakers .....	136.77
Printing and stationery .....	56.75
Registration .....	30.00
	518.52
Balance, May 31, 1958 .....	\$225.20

#### COMMITTEE ON MILITARY AND VETERANS AFFAIRS

Under the supervision of the Committee on Military and Veterans Affairs, and with the cooperation of the ad hoc Committee on Fees for Medicare and the Veterans Administration, a new fee schedule has been submitted to the Veterans Administration, designed to bring fees for VA patients nearer to the level of Medicare fees, which have been found acceptable both to the government and to the medical profession. At this time, approval of the schedule has been implied but not officially granted by the Veterans Administration.

Our Committee last year recommended to the House of Delegates that investigation of an intermediary type contract be undertaken. In the interim, the Veterans Administration has revised its procedures so that all payments for medical care are made through the local Veterans Administration in Wilmington. This has seemed to us to accomplish the desired effect of local administration, while avoiding the complications of fourth party intervention. Consequently, no action has been taken to change the type of contract.

When official action is received on the new schedule, each member of the Society will receive a copy. Meanwhile, the Committee points out that each physician in Delaware may treat service-connected conditions at the expense of the Veterans Administration, provided that this care is approved by the VA before treatment is begun.

Respectfully submitted,  
CHARLES F. RICHARDS, M.D., Chairman

#### COMMITTEE ON MEDICARE ADJUDICATION MEDICAL SOCIETY OF DELAWARE

Mr. President and Members of the House of Delegates:

Your Committee on Medicare Adjudication has had several cases this year. We are giving a summary of them without mention of names, giving largely the type of case and our disposition. All the records are in the hands of the Executive Secretary, Mr. Lawrence C. Morris, Jr., and you may see them upon request.

1. Request from surgeon for authorization of fee not included in schedule—approved by Committee—Accepted by ODMC.
2. Request from surgeon for authorization of laceration repair—approved by Committee—Accepted by ODMC.

3. Request from surgeon for authorization of laceration repair—approved by Committee—accepted by ODMC.
4. Request from surgeon for authorization of fee for muscle biopsy, not included in Schedule—approved by Committee—refused by ODMC; diagnosis was chronic disease for which no acute exacerbation was shown, making item non-payable.
5. Request from obstetrician for post-surgical complications beyond the ordinary—approved by Committee—accepted by ODMC.
6. Request from surgeon for authorization of laceration repair—approved by Committee—accepted by ODMC.
7. Request from ophthalmologist for authorization of fee for surgery not adequately covered by schedule—approved by Committee—accepted by ODMC.
8. Request from surgeon for authorization of fee for surgery not covered by Schedule of Allowances—approved by Committee—rejected by ODMC; condition was ruled chronic in absence of evidence of acute exacerbations.
9. Request from surgeon for authorization of laceration repair—approved by Committee—accepted by ODMC.
10. Request from surgeon for authorization of laceration repair—approved by Committee—accepted by ODMC.
11. Request from general practitioner for increase in obstetrical fee for complications of pregnancy—approved by Committee—accepted by ODMC.
12. Request from surgeon for approval of \$300.00 fee for surgery not included in Schedule of Allowances. Committee felt this fee not inherently unreasonable but incompatible with the income level of the Medicare patient. Committee recommended reduction from \$300.00 to \$200.00. Recommendation accepted by ODMC.
13. Request from general practitioner for increase in obstetrical fee for extra time spent with patient due to non-medical considerations in the patient's personal situation. Committee ruled this was not in accordance with local custom in the absence of medical complications, particularly with regard to a multipara-ruling accepted by ODMC.
14. Request from neuro-surgeon for fee beyond that listed in the Schedule of Allowances for a specific procedure. Fee voluntarily reduced upon neuro-surgeon's learning of Scheduled fee. Case therefore did not result in Committee recommendation.
15. Request from surgeon for fee beyond that listed in the Schedule of Allowances for specific procedure. Fee reduced voluntarily by surgeon upon learning of fee listed in Schedule of Allowances. Request did not result in Committee recommendation.
16. Request from obstetrician for \$296.00 fee for one month's prenatal care and delivery complicated by transfusion reaction, false labor, nephritis and anemia. Request necessitated by duplication of time items. Committee felt fee justifiable in other circumstances, not in accord with local practice regarding patients of the income group of the average Medicare Dependent. Committee recommended reduction of fee to \$191.00. Definite action of ODMC not received at this time.

Several cases have been received by the Committee in which no fee has been specified by the

physician submitting the claim. In each of these cases, the physician has asked that the Committee set a fee for work done. This is not within the sphere of the Committee on Medicare Adjudication, and these cases have not resulted in reports. In each case they have been referred back with explanation that the proper fee is the physician's normal fee or the fee specified in the Schedule of Allowances, whichever is less. The physician has been informed of his right to request adjudication if he considers the schedule of fee to be inadequate.

One case has been submitted of failure of ODMC to pay a hospital's claim after having paid the claim of the physician for the same case. It was pointed out that adjudication of hospital claims is not within the sphere of this Committee. It was further pointed out that rejection of the claim was predicated upon the hospital's listing of a chronic diagnosis without listing the acute exacerbations that made the case payable under Medicare. The hospital was advised to re-submit the claim with proper listing of these exacerbations. The Committee has heard nothing further from this case, and assumes that the report was re-submitted and paid.

#### SUMMARY

Sixteen cases within the jurisdiction of this Committee have been submitted since the Committee's last report. Eight of these were handled by the presently constituted Committee. Ten cases were approved by the Committee and accepted by ODMC. Two were approved by the Committee and refused by ODMC on the basis of non-payability of the diagnosis. In two cases, the fee requested by the physician was recommended for reduction by the Committee on the basis of its being higher than normal in the community for patients of the income level of the Medicare Dependent. In two cases, the fees were voluntarily reduced by the physicians involved upon learning that they were higher than those listed in the Schedule of Allowances.

Several cases were received that were beyond the jurisdiction of this Committee. The report should urge physicians to realize that it cannot assign fees to procedures, but can only pass upon the reasonableness and compatibility with the general level of Medicare fees of charges submitted by physicians.

Your Committee is quite concerned about the whole Medicare situation. As you know Congress debated whether or not to continue the Medicare service. Some of the Senators seem to think that the families of the service men could receive all of the attention necessary in Army hospitals and in other government institutions without having the Medicare program. They claim that it is too expensive and they want it entirely abolished. That has not been done up to now but there has been marked curtailment in the appropriation. There will be a twenty percent decrease. The Kent County doctors will feel this decrease more than the doctors in the other parts of the state because of the large government installation there.

It is possible that the doctors themselves throughout the country are responsible for the attitude of the Congress and of the Secretary of Health and Welfare. It has been our observation that there is a tendency for some of the doctors not to do anything wrong, but to squeeze the last penny out of these cases that they possibly can. In fact some of their fees are higher than they would get in private practice. If that attitude is continued the pro-

gram will be too expensive for the government and it will eventually be discontinued.

We recommend to those who have occasion to use Medicare service to do exactly as if they were handling private patients showing them all consideration in particular reference to their financial standing.

"Medicare officials, after another look at the account books, see the possibility of a shutdown of the civilian phase of the program early in 1959. The reason is relatively simple: the \$72 million appropriated by Congress for the fiscal year will not be adequate. And Senate and House conferees agree that the armed forces should not spend more than that amount."

Respectfully submitted,  
 E. R. MAYERBERG, *Chairman*  
*Medicare Adjudication*  
 L. B. FLINN  
 O. A. JAMES  
 W. F. PRESTON  
 H. W. SMITH  
 G. M. VANVALKENBURGH  
 R. O. Y. WARREN

**REPORT OF THE COMMITTEE ON  
 MEDICAL SERVICE AND  
 PUBLIC RELATIONS**

The Committee on Medical Service and Public Relations has concerned itself with four major projects during the year past.

Individual health information cards to be provided by physicians to the lay public are in preparation. These are designed primarily for use in disaster or emergency situations, and contain information on the identity and medical history of the patient, together with the family physician's name. These cards will be printed in large quantity and samples mailed to each member of the Society. Members who request additional quantities for distribution to their patients will receive them at no cost.

The Committee has in preparation a series of newspaper columns to be offered without charge to each newspaper in the state. We anticipate that these will appeal primarily to the weekly newspapers, which have an estimated readership of 175,000 in Delaware. This column will appear under the authorship of "Members of the Medical Society of Delaware". They will be evaluated for accuracy before dissemination, and will have been rewritten and edited by a single individual to insure continuity of style. Several physicians have furnished material for columns, and others have undertaken to do so. The Committee earnestly solicits the help of all Delaware doctors in providing material to be used in this project. We are interspersing information about medicine in Delaware and in the country with strictly technical material written for the public, and would welcome material from any physician who has a subject he feels should be discussed through this medium.

The Committee is planning, with the approval of the Council, a series of sessions on the practice of the art and business of medicine for new physicians. It is our feeling that today's medical education does not adequately prepare the young physician to enter private practice. While scientific preparation is undoubtedly better than it has ever been, the increasingly complex problems of financing an office, and meeting the many legal, tax and other technical obligations has assumed an importance that it has not always had. The Committee

will try to ease these problems for those entering practice.

The Committee is exploring, but has not acted upon, a plan to facilitate the dissemination of clinical news to the press. We feel that the medical profession would benefit from more and better public knowledge of its accomplishments. We are examining the possibilities of establishing in each hospital a contact to spot clinical news as it develops. The Society's office may contact this person periodically and refer such stories as may develop to a subcommittee of the Committee on Medical Service and Public Relations, whose function it will be to evaluate the reports. On recommendation of the subcommittee, these stories will be presented to the news media with competent evaluation of their significance. We anticipate that the media will be willing to cooperate and feel that this project, if it proves practical, will have an extremely good effect upon the public relations of the profession.

**PHILOSOPHICAL QUOTE A REMINDER**

"There are men and classes of men that stand above the common herd, the soldier, the sailor, the shepherd not infrequently, the artist rarely, rarelier still the clergyman, the physician almost as a rule. He is the flower of our civilization and when that stage of man is done with, only to be marveled at in history, he will be thought to have shared but little in the defects of the period and to have most notably exhibited the virtues of the race. Generosity he has, such as is possible only to those who practice an art and never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what is more important, Herculean cheerfulness and courage. So it is that he brings air and cheer into the sick room and often enough, though not as often as he desires, brings healing."

To the few who are willing to prostitute their profession for personal gain, let us direct the epithet which John Randolph of Roanoke once hurled at one of his contemporaries; "So brilliant, yet so corrupt, that like a dead fish by the moonlight, he shines and stinks."

Respectfully submitted,  
 H. THOMAS MCGUIRE, M.D.

**COMMITTEE ON MEDICAL ECONOMICS**

The Committee on Medical Economics was appointed largely to investigate the implications of medicine's being represented to the public by commercial enterprises in which physicians have neither control nor adequate representation. We have been particularly concerned with telephone service, especially answering exchanges, which have not always produced the desired results in New Castle County and which have been non-existent in Kent and Sussex counties.

There are three phases to the problem of control of this type of enterprise by the Society. These are desirability, effect upon the tax and charter positions of the Society, and economic feasibility.

It has seemed desirable that physicians exercise direct control over their answering and emergency call service if the remaining two criteria could be met.

From superficial study, it appears that the present charter of the Medical Society of Delaware would authorize activities of this kind. In the event that more thorough work proves that this is not the case, and alteration of the charter, if authorized by the House of Delegates should be a

simple matter. The effect upon the Society's tax position would be somewhat more complex. The present tax exemption is as a "business organization", so requested because it allows the Society to interest itself in legislation. Under this exemption, operation of such a service to the membership is not allowable. This problem could be met by shifting the exemption to "scientific and professional organization". The qualifications for this category provide that no substantial part of the Society's efforts can be in influencing legislation. We have secured a tentative ruling that "substantial" is construed to mean 25% or more. Since 25% of the Society's time is obviously not directed toward legislation, this appears to be a feasible course.

The economic possibility of such a project is a much more complex question, and the Committee has not arrived at a final answer. The Committee thinks that the answer may lie with small, desk-size switchboards recently developed by the telephone company, which might be placed in each of the hospitals in Kent and Sussex county, to be operated by switchboard operators already on duty with additional payment by the Society for the assumption of additional responsibility. Board charges would be quite low, appearing to be about 4-5 dollars per doctor per month. To this must be added line charges, which will vary with the location of the individual office (although there would be no charge for offices within  $\frac{1}{2}$  mile of the switchboard) and personnel costs. It is the Committee's information, necessarily tentative pending completion of studies by the telephone company, that service could be extended to all or almost all, physicians in this state at charges approximating, or slightly less than those now existing in New Castle County. Technical difficulties with the locator-concentrator, in which the Committee had hopes, point to the use of several decentralized switchboards, rather than one or two major installations serving the state as a whole. The Committee will be able to report more fully upon this project pending the completion of studies now in progress by the telephone company. Meanwhile, we would be interested in any comments the House of Delegates care to contribute.

Respectfully submitted,  
LESLIE W. WHITNEY, M.D., Chairman

#### VIRUS LAB MAJORITY REPORT

Mr. President and Delegates:

It gives me great pleasure to present the majority report of the Committee on the Virological Diagnostic Facility for our State. The members of the Committee appointed by Dr. John B. Baker are as follows:

DR. GEORGE J. BOINES, Chairman  
DR. JOHN B. BAKER  
DR. E. M. BOHAN  
DR. L. B. FLINN  
DR. F. I. HUDSON  
DR. L. P. LANG  
DR. C. LEVY  
DR. ROGER MURRAY  
DR. O. J. POLLAK  
DR. A. TORMET  
DR. M. A. CLARK, D.V.M., Advisor  
DR. J. C. KAKAVAS, Ph.D., Advisor

The Committee met on January 17, 1958 and after considerable discussion "it was agreed that no publicity concerning this project should be issued until the plans are more firm. It was agreed however, that Dr. Boines be empowered in his

fund-raising activities to state that this committee is in favor of such a laboratory, provided that adequate financing is available". A sub-committee was appointed to locate a site for this virological laboratory; this Committee reported that the Wilmington General Hospital agreed to place it on the ground floor of the Doris Memorial Unit on condition that a 3 year budget of \$60,000 was made available for its maintenance and operation at no expense to the hospital. The State Board of Health has also offered space at the Tallman Building at the Bissell Hospital under the same conditions. In the meantime I have contacted a few sources for funds and thus far \$31,750 has been assured.

On February 27, 1958 a sub-committee visited the USPHS Virus Diagnostic Laboratory at Bethesda, Maryland. Dr. John P. Utz, virologist in charge, was very courteous, showed us their set-up and explained the practicability of the commercially available tissue cultures. He stated that in his opinion, a viral diagnostic laboratory is an important adjunct to medical practice and would become increasingly necessary in the practice of medicine. This same opinion was expressed by Dr. J. C. Wilt, virologist at the University of Manitoba whom I visited last April.

Letters and official actions favoring the establishment of such a laboratory have been recorded from the following:

The Delaware Chapter of the American Academy of General Practice  
The Medical Staff and Medical Board of the Wilmington General Hospital  
The Lay Board of the Wilmington General Hospital  
The Chiefs of Staff and the Research Committee of the St. Francis Hospital  
The Lay Board and Administrator of the St. Francis Hospital  
The Sussex County Medical Society  
The Beebe Hospital  
Dr. A. R. Shands, Jr., Director of the Alfred I. duPont Institute  
The Emily P. Bissell Hospital  
The Kent General Hospital  
The State Board of Health  
The Wilmington Board of Health  
The Sussex County Chapter of the National Foundation for Infantile Paralysis  
The Kent County Chapter of the National Foundation for Infantile Paralysis  
The New Castle County Chapter of the National Foundation for Infantile Paralysis.

Neither the Delaware Hospital nor the Memorial Hospital has formally approved or disapproved the establishment of a laboratory in Wilmington. Each hospital has recognized the value of viral diagnostic work.

At the last meeting of the Committee, August 14, 1958, it was reaffirmed by all except one member, Dr. L. Flinn, that Virus Diagnostic Laboratory in Delaware was desirable. Dr. Floyd Hudson, Secretary of the State Board of Health, stated that "if the House of Delegates of the Medical Society recommends establishment of the laboratory, funds will be available".

Before I close I wish to express my appreciation to our Society for appointing this committee last year and to thank the members of this Committee and Mr. Lawrence Morris for their assistance.

At this time I move Mr. President, that this report be accepted and that you accept the Committee's motion which reads:

"The Committee on the Establishment of a Virological Laboratory recommends the establishment of a virus laboratory in the Wilmington area under the supervision of a competent virologist, and that the present Committee be permitted to continue to operate and assist in any way until the laboratory is established".

Respectfully submitted,  
GEORGE J. BOINES, M.D., *Chairman*

**MINORITY REPORT**  
**COMMITTEE ON ESTABLISHMENT OF A**  
**VIROLOGICAL LABORATORY**

I respectfully submit a minority report to the Council and House of Delegates. I voted against the Committee's recommendation that the Medical Society of Delaware approve or recommend the establishment of a viral diagnostic laboratory for Delaware in the Wilmington area.

My reasons are summarized as follows:

1. If the Medical Society of Delaware should recommend the establishment of a Virus Diagnostic Laboratory it would thereby indicate that the medical profession of Delaware was of the opinion that such a laboratory would provide a service for the community not otherwise available and that the expense and effort involved would be justified. It is my contention that such is not the case. Such a statement by the Medical Society of Delaware would be unfortunate.

2. I have long been actively interested in providing viral diagnostic facilities for Delaware. Methods of diagnosis are now more simple, but the number of known viruses is increasing so rapidly that only a laboratory with wide range of facilities is practical. At the present state of knowledge such a laboratory for this community alone is not realistic.

3. At the first meeting, January 17, of the Committee, it was voted that a laboratory would be nice to have in Delaware if money and other facilities, including a top-flight virologist, were available. Dr. Boines inferred that they were. The Committee suggested that he secure more definite information but not to solicit funds in the name of the Committee or the State Society.

4. On February 27, Dr. Boines and one other member of the Committee and a pathologist and Mr. Morris visited Bethesda, secured certain information from a small in-patient laboratory, and reported this information to the Committee. This report was later circulated in the name of the Committee to solicit funds. The Committee has never yet approved this Bethesda report. It is not realistic. I personally secured opinions from a large number of virologists throughout the country of wide experience, authorities in the field, and presented their opinions to the Committee at its meeting on August 14. I attach that report which I have not published or circulated.

5. I offered a motion at the August 14 meeting that the Committee recommend that a Virus Diagnostic Laboratory not be established at this time but that the facilities available to us in the U. S. Public Health Laboratory in Philadelphia, one of thirty along the Atlantic seaboard be used to better advantage. This motion was not even accepted for a vote.

6. At the August 14 meeting, it was distinctly agreed that funds were not to be solicited in the name of the Committee of the State Society. However, three days later a letter did go out to various organizations over Dr. Boines' signature mention-

ing that the Committee had voted that a Virus Diagnostic Laboratory be established and strongly urging that the organizations to which the letter was sent contribute a specified amount each year. This I strongly object to.

7. I have been asked by the Chairman to present a plan to facilitate services from the Virus Diagnostic Laboratory in Philadelphia. I attach this plan and recommend its adoption subject to change as experience indicates. Certainly it will give us immediate service, far more effective and at far less cost than the establishment of a full-fledged, top-flight Virus Diagnostic Laboratory in Delaware at this time.

L. B. FLINN, M.D.

PRESIDENT BAKER: You have heard the reading of these two reports. The floor is now open for discussion.

DR. BOINES: Mr. Chairman, may I reply to some of those complaints of the minority report?

PRESIDENT BAKER: Yes, you may.

DR. BOINES: Mr. President and Delegates:

As most of you know, Dr. Lewis Flinn and I have been feuding over viruses since 1947. The report of the majority of the committee, however, is not based on personal interest of myself or Dr. Flinn. The members want a virus laboratory established or sponsored by the Medical Society of Delaware because of the facility and the benefits that it will bring to the doctors and to the people of Delaware in making diagnoses of viruses.

I would like to submit the following statement, and I hope you keep in mind, whichever way you vote, you are voting for a new facility in the State of Delaware and you are not voting for me or Dr. Flinn.

I am in agreement with Dr. Flinn that viruses are here to stay, that virus diagnoses are simpler and that the diagnoses can be made earlier and more accurately if the specimens from an acutely ill patient can be processed immediately by a well-equipped laboratory.

In my personal visits to a number of virus laboratories and discussions with virologists, I was impressed by the following information.

Dr. Werner Henle, virologist of the Children's Hospital, Philadelphia, Virus Laboratory, stated "There is no doubt that more virological diagnostic laboratories are needed" and that he would be happy to assist our Society in its efforts.

As far back as 1949 Drs. Sigel, Henle, and McNair Scott of the Children's Hospital in Philadelphia, stated that "The Public Health program, as well as the practice of medicine by the individual physician are not complete without the diagnostic and epidemiologic services of a virus laboratory. The need for the establishment of a special unit for the diagnosis of viral and rickettsial diseases is evident from the observation of recent trends in infectious diseases. The functions of a virus diagnostic laboratory are: (1) aid in the diagnosis of disease in individual patients; (2) aid in determining sources of infection involving single, family or neighborhood cases; (3) aid in the diagnosis of larger outbreaks and epidemics."

Dr. John P. Utz, Director of the Clinical Virus Laboratory at National Institute of Allergy and Infectious Diseases, Bethesda, stated, "In fact, we envision the day when a virus diagnostic laboratory will be an integral part of a clinical pathology department as is the bacteriology laboratory now."

Dr. J. C. Wilt, virologist at the University of Manitoba, emphasized to me that as scientific physicians we owe it to our patients to obtain an accurate and early diagnosis of their virus infections. We can thus avoid using many unnecessary tests and therapeutic agents and at the same time allay the anxiety of the patient and his family as to the cause of the infection. Also emphasized was the importance of early virus diagnosis from the epidemiological angle. Last year, Dr. Wilt's laboratory was able to discover Asiatic Flu cases early, isolate them, and minimize the spread of the disease. Earlier vaccination was made possible in non-infected areas so that an epidemic was avoided. At the present time many infections diagnosed as "fever of unknown etiology" can be solved by virological studies.

The above authorities are clinical virologists who work with patients and have personal experience with the practical aspects of virology.

Dr. Jas. C. Kakavas, bacteriologist and chairman of the department of biological sciences at the University of Delaware has stated that a virus laboratory is essential in daily medical diagnosis of viral diseases and differential diagnosis of patients who appear to have viral infections. A laboratory in the Wilmington area would be readily accessible from all the populated areas within the State of Delaware and also from the neighboring communities of Pennsylvania, New Jersey, and Maryland. Such a laboratory would furnish diagnostic services, epidemiological studies, and research on viral diseases. In a letter to our committee on 7-28-58, Dr. Kakavas stated "I earnestly hope that the members of the committee will approve the establishment of this facility and with their support I am certain that the necessary financing will be forthcoming."

In a letter received from Dr. Charles Benning, Health Commissioner of the Wilmington Department of Health, he wrote, "In accordance with my conviction of the need for the establishment of a virus diagnosis laboratory in Delaware, I wish to go on record as endorsing such a plan. I feel that it is essential for the health and welfare of the people of Delaware that this endeavor be supported."

Dr. Flinn states that we have no specific therapy for viral diseases therefore why diagnose them? By the same token, we should not make any effort to diagnose any disease for which we offer no specific therapy to the patient but we all know their value. Let me emphasize that it has been vividly demonstrated by the Asiatic Flu experience of last winter, that 50% or more of the deaths in these patients were due to *Staphylococcus Aureus* Coagulase positive organisms. These organisms were found sensitive to some of the antibiotics. It was also shown that many patients developed viral myocarditis with fatal results. Thus an early diagnosis of Asiatic Flu (this can be had in 24 hours) would enable the physician to isolate and treat the Staph. infection and also watch carefully for signs of myocardial failure. To another contention that viral diagnoses do not help the patient therefore the patient should not be charged for virus studies, I would like to say that we daily request expensive laboratory tests such as X-rays, electro-encephalograms, cardiograms, and isotope studies, which are negative in their findings but for which the patient has to pay.

On Friday, 9-19-58, Dr. Morris Schaeffer, consultant for the USPHS Communicable Disease Center in Atlanta, Ga., and Medical Director of the Virus Laboratory in Montgomery, Alabama, came to Wilmington at the request of our committee and

the personal efforts of Dr. Floyd Hudson. Dr. Schaeffer stated that it is important to start a virus laboratory in the State even though it is on a modest scale in the beginning, because one should not depend indefinitely on an outside laboratory to carry the load. If a laboratory is already in operation any improvements in testing and research in discovering cures for different viruses will enable the physician to take advantage of this new knowledge immediately for the benefit of his patients. For example, within the next 2-3 years the fluorescent antibody technique for diagnosing viruses will be fully developed.

Dr. Schaeffer sent a letter to Dr. Hudson, a copy of which I received yesterday. Dr. Hudson, do you mind if I read this?

DR. HUDSON: You may read it.

DR. BOINES: This is a copy of a letter to Dr. Hudson:

"Dear Dr. Hudson:

"I was very pleased indeed to have an opportunity of consulting with you and Dr. Boines concerning the development of a virus diagnostic laboratory as a cooperative effort of the State Health Department, the local hospitals, and the university, last week. As I pointed out, the space at the Wilmington General Hospital is not adequate but the space and facilities available at the Bissell Hospital Sanitarium are admirably suited for this endeavor. The willingness of the various groups, including the hospitals and university, to cooperate with the Health Department should facilitate more rapid progress in the development of a good laboratory and it is obvious that there is considerable advantage in having one well organized, adequately functioning laboratory to serve all of the interests in the State than to have several inadequate ones.

"One may question the need for and usefulness of a virus laboratory at this time. While it is true that such a laboratory is fairly expensive to staff and operate, and may not always provide information of life-saving value, there are many other good reasons which support the desirability of having the facilities of such a laboratory available.

"Currently improved techniques are providing more rapid and accurate tests for at least some of the common virus diseases. A virus laboratory can provide important information to the health officer and physician concerning the definitive prevalence of disease. There are quite a number of respiratory, enteric, and CNS infections which cannot be differentiated on a clinical basis and only a competent laboratory can assist in such differential diagnosis. There are a few virus diseases, such as psittacosis and lymphogranuloma venereum which respond to broad spectrum antibiotics and it is expected that others will be added to the treatable group since there are many investigators diligently seeking a suitable chemotherapeutic agent. On the other hand, there are many diseases that should not be treated with antibiotics and this can be avoided when a specific diagnosis is at hand. Those who claim that the laboratory diagnosis of a viral infection is obtained in retrospect, and thus is useless, might be asked whether it is also useless to do a post mortem examination since the patient has expired.

"I feel rather strongly that when at all possible a virus diagnostic laboratory should be available to state health departments and physicians locally, rather than for them to have to depend upon distant facilities to provide such services. The laboratory could start modestly with the minimum equipment and offer a limited number of tests.

There could be gradual expansion of activity as funds and staff can be accumulated.

"While it is unfortunate that the Public Health Service does not have funds to assist you with this project, you can call on us for advice and consultation, technical assistance with difficult specimens, the training of personnel, and for certain diagnostic reagents which are not available commercially. If you should go forward with your plans for developing this laboratory, we should be pleased to have you call on us for any help we may be able to furnish in the categories mentioned.

"Sincerely,  
"Morris Schaeffer,  
"Medical Director."

The inconvenience, the expense and the time lost in preparing and shipping specimens properly, is a big factor to be considered, not to mention the breakage in transit. The USPHS will cooperate with the State Board of Health in supplying antigens and sera, consultation and teaching facilities for the laboratory and Delaware physicians.

The anticipated laboratory will be the result of the combined efforts of the community, the hospitals, physicians, industry, and the City and State Health Departments.

Now, I have letters to answer all the questions and accusations that Dr. Flinn is making in his report. You can rest assured that they are all misleading or inaccurate.

DR. WASHBURN: Your letters?

DR. BOINES: No, they are not my letters. For instance, the one statement that the last committee said I should not ask for funds and three days later I sent out a letter to that effect. The committee meeting was on the 14th of August and the letter was sent out to the Heart Association and to the Tuberculosis Association. I think the Tuberculosis Association is the one to which he refers. That was sent out on the 25th, and I did not put the name of the Society in jeopardy by saying that the Society is in agreement and therefore we should have the funds. As a matter of fact, the money that we have raised so far has been assured so far, the \$31,750.

As a matter of fact, I made a special effort to let the people know that Dr. Flinn and the Delaware Hospital were opposed to this virus laboratory. In fact, that helped in getting the funds faster. The first paragraph which I wrote was: —and this was on July 25.

"Dear Mr. Evans:

"A committee appointed by the State Medical Society has approved the establishment of a virus diagnostic laboratory in Wilmington on condition that funds be raised to initiate the program. I have been asked as chairman to investigate the availability of funds for this purpose."

That is the authority that I was given by the committee.

Thank you very much, gentlemen. If there are any questions you wish or any other letters you want to see, they are all here, and they are not mine. Unfortunately Dr. Washburn is not involved in this argument on viruses.

PRESIDENT BAKER: Is there further discussion?

DR. TRICKETT: I would like to go back to the original report where Dr. Hudson said funds would be made available to the State Board of Health. If he is going to make the funds available, why are we raising funds? That is the first ques-

tion. Number two is, after you have your laboratory set up, who is going to procure and pay the salary of the virologist?

PRESIDENT BAKER: Dr. Hudson, would you like to answer that?

DR. HUDSON: I would like to clarify this. I read that in the report, but I had to be away and I didn't get the thing changed. I don't believe I was quoted exactly.

I did not, I believe, state that we expected to have funds from the State Board of Health to do this. I said there was no reason why, if the Medical Society wants this laboratory, that there aren't plenty of private sources from which we can get the funds to get the thing going. I believe that was substantially what I said, not the exact words, but that there should be funds in the State to get it going without going to the General Assembly to get funds to get it started, if that is what the Medical Society wants.

Now, what was the other question?

DR. TRICKETT: How are you going to procure a virologist and who is going to pay his salary?

DR. HUDSON: Well, the virologist and the setting up of the laboratory would have to be a detailed function which the committee would have to work out. In other words, they would have to raise the funds to pay for both of them. I want to make the position of the State Board of Health clear at this point. The State Board of Health does not propose to start a virus laboratory or to operate it for the general practitioners in the State unless they want it. They will have to ask for it. The State Board of Health does not do that sort of thing. We have use for such a laboratory ourselves, and if the laboratory is started in Delaware, we will utilize the facilities of that laboratory to perform tests for us so that we can follow the course of any outbreaks of disease, of which the origin or cause is unknown, to determine whether it is viral or not, if possible.

I feel that the State Board of Health would do this and would want to do it. After all, the majority of the members are in the medical and dental professions. Four of them are members of this Society. If the doctors want something, the State Board of Health will go along with them, I am sure, and help them in whatever way they can in what they want to do. If they want this separate laboratory set up and they will utilize it, we will try to subsidize to the extent that we use the facilities out of funds appropriated for our own laboratory operation.

Now, if here are any questions, I would be glad to try to answer them.

PRESIDENT BAKER: Dr. Flinn, would you like to give your reply now?

DR. FLINN: Mr. Chairman and members of the House of Delegates:

The issue seems to be somewhat confused. The question, as I see it, is not whether a virus diagnostic facility is desirable—I don't think there is any question about that—the question is, should we have one in Delaware or, as explicitly stated in the report, in the Wilmington area.

I have long been interested in virus diagnoses, and if somebody would like to give us in Wilmington a top-flight virus diagnostic laboratory on a silver platter, all expenses paid, I would be the first one to welcome it; it would be fun; I would enjoy it. But asking the State Society and the community to finance it is another matter.

In the present state of knowledge virus diagnosis is of main concern in the fields of public health and epidemiology in the field of education. It is of practically no help in the clinical care of a sick patient. The groups, therefore, who should be most interested in such a laboratory are the public health departments and the educational field.

It is of interest to know whether a certain individual has a certain type of virus disease, but it makes no difference whether you get that information 24 hours ahead of some place else. If there were a laboratory in Wilmington, I fail to see how that is any closer for people in Milford or Seaford or Dover than Wilmington at the present is from Philadelphia, and if in Milford or Seaford you must send specimens to Wilmington, I see no extra effort in sending them to Philadelphia. I have no stock in Philadelphia except it is one of the leading virological laboratories along the Atlantic Seaboard. And this is not just my opinion; it happens to be the opinion of a majority of the leaders in virology in the United States as to the importance of virus diagnoses in the care of a patient.

I did not want to take your time, but I have been asked by two individuals in the last ten minutes to read this to you, the report which I made to the August 14 meeting of the committee, which I summarized in my minority report which Dr. Cannon read. I will try to make it as fast as I can. It is as follows:

#### SUMMARY OF THE PRESENT STATUS OF THE FEASIBILITY OF THE ESTABLISHMENT OF A DIAGNOSTIC VIROLOGICAL LABORATORY IN DELAWARE

You all are, I am sure, by this time quite familiar with the widely publicized Bethesda report. According to various memoranda received from Dr. Boines and Mr. Lawrence Morris, Executive Secretary, on February 27, 1958 representatives of the Medical Society of Delaware and of its Committee on the Establishment of a Virological Diagnostic Facility visited a viral diagnostic laboratory of the United States Public Health Service, located at the National Institutes of Health, Bethesda, Maryland. However, there were only four representatives, Dr. Boines and Dr. Kakavas of this Committee with Mr. Morris as Executive Secretary, and Dr. Cassella, Pathologist at the Wilmington General Hospital, not a member of this Committee. The report presented a summary of information received from John P. Utz, M.D., Chief, Infectious Diseases Service, Laboratory of Clinical Investigation, National Institute of Allergy and Infectious Diseases. Apparently using this report as a basis, organizations and individuals were approached in regard to available space for such a laboratory. Apparently a virologist had also been approached. With the recent publication of this report in the State Medical Journal, although it was not so stated, the inference was plain that the Journal, and perhaps the State Society, approved the establishment of such a laboratory.

All this seems rather unfortunate since certain particulars of this Bethesda report do not seem quite realistic or applicable to the proposed diagnostic laboratory in Delaware. It should be pointed out that Dr. Utz in his laboratory has to do with an in-patient service of some fifty beds, and is not confronted with the many problems involved with virus diagnosis in an entire community. He stated that diagnosis can sometimes be made in fifteen hours; usually, however, after four or five days, and often ten to fourteen days. He further stated that prompt diagnosis is important

to the physician in the clinical care of a patient; and further, that recent methods have made virus diagnosis much simpler and cheaper. Much of this is contrary to the opinion of others more experienced in this field.

A short questionnaire was sent to the following: Dr. Werner Henle, Director of the Virus Diagnostic Laboratory in Children's Hospital of Philadelphia; George K. Hirst, M.D., of the Public Health Research Institute of the City of New York; Daniel Widelock, Ph.D., Assistant Director, Bureau of Laboratories, City of New York, Department of Health; Edwin H. Lennette, M.D., Chief, Viral and Rickettsial Disease Laboratory, California State Department of Health, Berkeley, California; and Dorothy M. Horstmann, M.D., Section of Epidemiology and Preventive Medicine, Yale University School of Medicine. They were all in essential agreement on answers to the following questions: (1) How advantageous would it be to have a virus diagnostic laboratory in Wilmington instead of using the Virus Diagnostic Laboratory in Philadelphia? Answer: No advantage in the present state of virus knowledge. In the future, when more practical developments will have occurred, it probably would be advantageous to have a proper laboratory in Delaware. (2) How important is it in the care of an individual patient to make a rapid virus diagnosis? Answer: Of no importance. No treatment available at present. (3) What method of diagnosis is more practical? It was generally agreed that, in establishing a diagnostic laboratory of this sort, it is far better first to choose the virologist and let him develop a laboratory; and further, it has been found more practical to start first with serological techniques only. Tissue culture, including both HeLa cells and monkey cells; and the use of chick embryo, and also of suckling mice which are necessary for the coxsackie group of viruses, are much more difficult to perform although a quicker result is obtained. (4) Do you agree with Dr. Utz that, by new techniques, diagnosis may be made rapidly, sometimes within fifteen hours? Answer: In a few instances such rapid diagnosis can be made but it is not realistic to suggest this as a basis for a laboratory doing a community service. The usual time is four to ten days. Sometimes only two sera are necessary to make a diagnosis, and in other of the more complicated but not unusual viruses it may be necessary to set up forty or fifty different tubes. On an average the number of different tests made on an individual specimen is four to ten. (5) Should the patient pay for the tests? No one answered yes, several said no, and one referred the answer to the local authorities. (6) Cost — all agreed that the cost was difficult to estimate but agreed that it is high, and higher per patient in a small laboratory. (7) Is it likely that a qualified virologist can be obtained to run a virus diagnostic laboratory full time? All answered no. The virologist must have as his main interest opportunity and facilities for

In April, 1958, a panel discussion was held at the meeting of the American College of Physicians, on Viral Diseases. The panel was composed of the following: Yale Kneeland, Jr., M.D., Associate Professor of Medicine, Columbia University College of Physicians and Surgeons; John H. Dingle, M.D., Professor of Preventive Medicine and Associate Professor of Medicine, Western Reserve University School of Medicine; Frank L. Horsfall, M.D., Vice President and Physician-in-Chief, Rockefeller Institute; John R. Paul, M.D., Professor of Medicine; Joseph E. Smadel, M.D., Associate Director, National Institutes of Health.

In answer to the question "How important is rapidity of diagnosis in the clinical management

of a case of virus disease?". Dr. Smadel answered that he has never known of a single instance when the diagnosis was of any aid in treating a specific case. (2) Should the patient pay for the necessary tests? Dr. Smadel answered, emphatically, "No". All the panel agreed.

Now, I didn't know about this until last night—I heard that this was reported on the Audio Digest. I have not heard this recording. It takes about two minutes. Dr. Hall, if you will start it, we will listen to what Dr. Smadel said.

(A tape recording was then played as follows:

"VOICE: Here is a question which is right down Dr. Smadel's alley: The inquirer wants to know how helpful in the care of a particular patient is the service of a virus diagnostic laboratory. In a given case should one use virus diagnosis by chick embryo or tissue culture with the immediate clinical expense? Should expenses of such diagnostic tests be borne by the patient?

"DR. SMADEL: That is a tough one. May I begin by saying I am prejudiced in favor of viral diagnostic work, but I must admit that as far as the individual patient is concerned and as far as the care of that patient during his acute illness by the physician is concerned, that I believe we have never in a single instance really been of any help. Now, if this were the main objective, I would have quit long ago. The virus diagnostic laboratory has a great role in public health and in preventive medicine, but it is unfortunately at this particular stage of relatively little help to a given patient and a given physician.

"All of the virologists know the problem of the physicians and have made great efforts to find rapid results. We may be on the verge in some instances—for example, the throat swabs from patients with influenza, the Russians have been excited in the last couple of years about the presence of what they think are fairly specific inclusions in certain of these smears. The Americans have not yet become excited about this. On the other hand, the Americans have become enthusiastic in the rapid diagnostic procedures which use fluorescent antibodies in a number of instances, and you are familiar with the fact that certain of the smears from throats, etc., where bacterial infections are occurring, that it is possible with fluorescent antibody techniques to identify these organisms as regards at least the group in the streptococcal field within a few minutes.

"Well, now, the virologist has not been idle during the past decade. He is worried about these things and tried to get some techniques to work, but he has never yet done it. I hope he will.

"Should one use tissue culture or chick embryo? The real problem here is like the old story, Gold is where you find it. In the virus isolation business sometimes one technique is better than another, so that one really looks at the patient's history, the material that he has at hand to attempt an isolation from and then chooses several different kinds of hosts which might be the most apt to yield the virus one suspects is there. Sometimes this is tissue culture, sometimes it is chick embryo, sometimes it is suckling mice, and sometimes it is guinea pigs.

"The final question, should the expense of such diagnostic tests be borne by the patient? It is my belief that they should not be because it is my feeling that a patient should be charged directly only for those things which are of help in arriving at a diagnosis for which one can provide some therapeutic help."

(End of tape recording.)

DR. FLINN: Therefore I feel that it is a mistake at this time for this Society to recommend the establishment of a virus diagnostic facility when it will suggest that we should approve of individuals or organizations contributing funds when the patient has little to gain over what we have to offer at the present time. I do feel that our present facility can be improved and can be made more accessible and much more practical in the ways in which we have indicated in the details of the report. What we really need is a courier to go not only to Philadelphia but from hospital to hospital to see that the material is delivered promptly and to follow it up and get the reports. I am all for a virus diagnostic laboratory, but I am not going to suggest to anyone that I think at this time you should give a nickel to it for the benefit of the patients of Delaware.

DR. BOINES: What would Philadelphia charge for those services, do you mind telling us?

DR. FLINN: I don't know, but at the present time one hospital, and for a while another hospital, was attempting to pay its own way, and it was divided on a population basis. I don't know what the figures are. I think the Delaware Hospital contributes about \$2500 a year. I think the Memorial at one time contributed about \$1600. I suppose if we had a courier service, you could get somebody for about \$300 a month perhaps. And if you divide all that up among the hospitals in the State, and maybe you can persuade the health organizations which are really the ones most interested, to contribute something, then I think the over-all cost would be not great.

PRESIDENT BAKER: Dr. Hudson?

DR. HUDSON: I would like the privilege of the floor. I would like to give you some facts that I had gotten from visiting the New York State Virus Laboratory and from talking with Dr. Schaeffer who visited with us on the 19th relative to what we can expect in the next few years in the science of the laboratory diagnosis in virology.

The technique which was mentioned on the tape there of fluorescent antibodies is apparently a very promising one, and much work is being done throughout the country, especially at Montgomery, Alabama. I am told, and I believe, as Dr. Flinn stated, with this particular test you can take throat washings and determine within a few minutes whether it was of a certain virus group or not. I asked Dr. Schaeffer specifically how soon this particular test would be available and used pretty generally. He said it should be pretty well perfected in a matter of from three to five years.

There are also other tests, other studies, going on which are aimed at speeding up the results and which would provide certainly for the clinician a good deal of help. If you could find out within a couple of hours after taking a specimen that it was say, an influenza "A" or something like that, you would know you need not do certain things at that time.

I believe that a laboratory in this State certainly would need at least a couple of years in getting started, and even if funds were available it would take some time to get it set up and to get a virologist. With the growth that is going on in this particular field, it certainly would be good if we could be on the ground floor and not come in after all these tests are going on and it is much more difficult as various places set up these laboratories to give this facility to physicians and health departments, it would be much more diffi-

cult to secure any technologists, and they are quite hard to get, as you know.

PRESIDENT BAKER: Dr. Frelick.

DR. FRElick: In view of the fact that this is a public health problem in large measure and Dr. Hudson is interested in this, I think that it might be well if the Society would urge the State Board of Health to investigate methods of improving the diagnostic viral facilities in the State either by setting up a branch laboratory in co-operation with the United States Public Health Laboratory in Philadelphia or establishing better courier service between the various hospitals and the Philadelphia Laboratory.

But I think this should be properly financed through public health funds and this would perhaps give us a method for doing this if we would urge it upon the State Board of Health as Dr. Hudson has intimated.

DR. BEATTY: Mr. Chairman, I move that the minority report of the committee be accepted.

(The motion was seconded.)

DR. BOINES: My motion was first.

DR. CANNON: Dr. Boines moved the acceptance of the majority report. I think we would have to act on that first.

DR. WASHBURN: Mr. President, could I by some method be given the privilege of the floor if there is no objection? I am not an officer and I am not on this committee.

I would like to invite attention first that members of a committee may participate in discussion, but if they are not members of the House of Delegates they are not privileged to vote or make motions, that in answer to Dr. Cannon's proposition.

Secondly, I think that this is an amazing recurrence of a very honorable tradition, namely, that here in this House of Delegates, the Medical Society of Delaware, we are once more in the business of dissent and disagreement. Here are two honorable members of the Society who firmly and conscientiously differ in their opinion as to what course should be followed here. I respectfully suggest that in the long run, and to the greatest good for the greatest number, it would be better for us not to adopt either report, either Dr. Beatty's motion or the one by Dr. Boines. I may say that the report could have very properly said that the committee recommends such and such action. But nevertheless here are two different points of view.

In my own judgment the weight of authority, as expressed on the one hand by Dr. Boines and on the other by Dr. Flinn, the weight of authority in my opinion rests with the minority report. But in the centuries gone by, those of us who had any interest in the history of medicine must recall that on many, many occasions constituted authority was in error, was wrong.

So I respectfully suggest that it would be better if this House of Delegates were to receive the report of the committee, both majority and minority, and not authorize or recommend any action whatsoever than to suggest that the committee be continued for another year, and if by any chance private funds were made available to properly equip and properly maintain and carry on even the beginning of a laboratory, no great harm can possibly come from such a course of action, and possibly good might come from it.

So I would hope, if my suggestion is thought well of, that someone will recommend as I have suggested, that we receive the report, that the com-

mittee be continued in office and authorized to proceed in their studies and in their efforts to obtain money with which to set this project going.

May I add that if it happens that the facilities even in the beginning are not sufficient at the Wilmington General Hospital, I know of no good reason why the Board of Health shouldn't make available the facilities of their Bissell Sanitarium, even as a private enterprise, do you, Dr. Hudson?

DR. HUDSON: It could be as a private enterprise.

DR. WASHBURN: I respectfully submit that recommendation.

DR. CANNON: I have attended a number of these committee meetings and virology is not prominent in my practice, but I am interested in it, and I like what Dr. Washburn has said, but I would like to point out to the House of Delegates that last year in authorizing this committee to proceed they did not have any intention, as I recall, of having the Medical Society of Delaware operate a laboratory. This committee was merely to investigate the desirability, feasibility, practicability of such a laboratory and to lend its support, or not, to any group that would like to form such a laboratory.

I certainly would not like to see the Medical Society of Delaware operate a laboratory. It is not the function of the Society nor of the committee. And the committee's recommendation was actually support for the idea of such a laboratory so that any group, whether it be an independent corporation or a hospital would have the support of the medical profession of Delaware, the medical community would give its blessing to any such laboratory.

I can see if this House of Delegates would vote to support the State Board of Health in requesting appropriations from the Legislature for the establishment of a virologist, Dr. Hudson would be very grateful and could take our recommendation to the Legislature and ask for funds, and maybe the laboratory should properly be with the State Board of Health, and the medical community would function through the State Board of Health, as we do with a number of other services of epidemiological importance and apparently of very little clinical importance.

If the Wilmington General Hospital or the Delaware Hospital or the Memorial Hospital tomorrow would have a benevolent donor who would give them enough funds and would announce they are starting a virus diagnostic service as a part of the laboratory, Dr. Abbiss, Dr. Cassella, or someone else, the State Society would have no business in saying, well, that is wrong, or that is bad, that you should set up an isotope laboratory or an electroencephalographic department. Those things are the function of the hospital and the hospital asks for funds.

So that before this committee or Dr. Boines or any group went to ask for support for this idea, the purpose of the committee was to get the atmosphere, the climate of opinion regarding the formation of this laboratory. And I think that is the thing the House of Delegates has to decide, whether they want to take no action at all and it still can be independently started with or without our blessing, or the House of Delegates can say, "Yes, we think this is a good idea, and any group that would like to go and formulate such a laboratory has the blessings or the support of the doctors, the medical community in Delaware." I think that is all the farther we can go. We are not directing any one to solicit funds; we are not going to operate

a laboratory; we are not going to organize a laboratory. This is only a policy body.

PRESIDENT BAKER: Time is growing late. Is there any further discussion? The chair will automatically limit it from now on.

DR. WASHBURN: There is nothing before the House.

PRESIDENT BAKER: You have heard the various discussions. You have heard the proposals and the suggestions. If you are ready to act, do you want to act on Dr. Beatty's motion?

DR. CANNON: I think we should act on the majority report which had a recommendation.

DR. BEATTY: There is a motion before the House.

DR. BOINES: How about mine?

PRESIDENT BAKER: Are you a member of the House of Delegates?

DR. BOINES: I am a member of the committee.

DR. CANNON: The majority committee report contains a recommendation which has to be acted on first.

DR. FRELICK: There was no recommendation from the floor that should be acted on so far.

DR. CANNON: It is the committee's motion.

DR. WASHBURN: The committee has no right to make a motion. The only motion really made was that of Dr. Beatty, and so far as I know it was not seconded.

DR. FRELICK: I seconded it.

DR. WASHBURN: I beg your pardon. Then Dr. Beatty's motion is before the House.

PRESIDENT BAKER: You have heard Dr. Beatty's motion that the minority report be accepted.

DR. COMEGYS: I would like to hear that read.

PRESIDENT BAKER: You mean the minority report?

DR. COMEGYS: Not the minority report, I mean the very last sentence there.

DR. BEATTY: I moved that the minority report of the committee be accepted.

DR. COMEGYS: Did he end up the minority report with a recommendation?

PRESIDENT BAKER: The majority report ended with a recommendation.

DR. FRELICK: The minority report did, too.

DR. BOINES: Can't a member of the committee bring that up?

PRESIDENT BAKER: Dr. Comegys, which report did you have reference to?

DR. COMEGYS: The minority report, the motion.

FROM THE FLOOR: The minority report recommended the adoption of the attached plan that he submitted.

PRESIDENT BAKER: Well, as I see it, there is a motion before the House.

DR. CANNON: Why not ask Dr. Flinn to state a motion, not that the minority report be accepted.

DR. BOINES: He is not a Delegate either.

DR. BEATTY: You have a motion on the floor. You have to do something about it.

PRESIDENT BAKER: Well, you have heard the motion on the floor. We probably have to act upon

that first. All in favor of the minority report say "Aye".

(There was a chorus of "Aye's".)

Opposed, "No."

(There was a chorus of "No's".)

PRESIDENT BAKER: It sounds like the "Aye's" have it. Suppose we have a show of hands on that. All in favor of the minority report hold up your hands.

(17 members raised their hands.)

PRESIDENT BAKER: All opposed to the minority report hold up your hands.

(8 members raised their hands.)

PRESIDENT BAKER: It has been moved, seconded and carried that the minority report be accepted by this House of Delegates. I think that this particular subject probably should be kept under consideration in the future because since virology has taken such an important step, we certainly don't want to be behind the eight-ball at a later date. It might be in the province of the State Board of Health at some time to set up such a laboratory.

DR. MCGUIRE: What is the status of Dr. Boines' committee?

PRESIDENT BAKER: That is just what I was getting ready to ask. Does the House wish to have this committee reappointed, carried over to the following year to further consider studies in this particular field and to report back to the next meeting of the House of Delegates?

(A motion was made and seconded.)

PRESIDENT BAKER: It has been moved and seconded that this committee be reappointed with power to continue the study and report back to the next meeting of the House of Delegates.

The motion was carried.

#### REPORT OF DELEGATE TO A.M.A.

Mr. President and members of the House of Delegates:

It is my privilege as your delegate to the House of Delegates of the American Medical Association to report to you on the activities of that body during the past year. There were two meetings since my last report, the interim session meeting in Philadelphia in December, 1957, and the annual Scientific Meeting in San Francisco in late June of 1958.

One of the features of the Philadelphia meeting was the presentation of a Gold Medal Award as the General Practitioner of the Year to Dr. Cecil W. Clark of Cameron, Louisiana. Dr. Clark, a thirty-three year old country physician, was a medical hero during hurricane Audrey in June of 1957. The Board of Trustees selected him as the General Practitioner of the Year and he was so honored by an appropriate ceremony.

The most controversial issue dealt with at the Philadelphia meeting was the matter of fluoridation of public water supply. The House of Delegates approved a joint report of the Council on Drugs and the Council on Foods and Nutrition, which endorsed the fluoridation of public water supplies as a safe and practical method of reducing the incidence of dental caries during childhood. A brief summary of the voluminous report on the study which was directed by the House at the Seattle Clinical Meeting one year ago is

worthy of insertion in this report and contains the following conclusion:

1. Fluoridation of public water supplies so as to provide the approximate equivalent of one ppm. of fluorine in drinking water has been established as a method of reducing dental caries in children up to ten years of age. In localities with warm climates or where for other reasons the ingestion of water, or other sources of fluorine is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates, as well, a reduction in the rate of dental caries up to at least forty-four years of age.

2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the approximate equivalent of one ppm. of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) occurring with this level of fluoridation, is minimal.

3. Fluoridation of public water supply should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than the equivalent of one ppm. of fluorine.

The final adoption of this resolution after years of research, investigation and debate reflects credibly on organized medicine's continuing dedication toward improvement of the health of the American public.

The House, in its vigilance toward the preservation of the free choice of a physician in American medical practice, took note of several threatening elements. It condemned the current attitude and method of operation of the United Mine Workers of America Welfare and Retirement Fund as "tending to lower the quality and availability of medical and hospital care to its beneficiaries". This Section called for a broad educational program to inform the general public, including the beneficiaries of the fund, concerning the benefits to be derived from the preservation of American rights to freedom of choice of physicians and hospitals, in contrast to closed panels and institutions for the treatment of their subscribers. It observed that it would be unethical if a reasonable degree of choice of physician is denied to those cared for in a community where other competent physicians are readily available.

Although we in Delaware, fortunately are not faced with the same problems as are our colleagues in Pennsylvania, Kentucky, Ohio and Colorado, it is well known that regional invasion in the free choice of physician may ultimately affect us all.

Conscious of the necessity of an efficient functioning organization, the House considered the Heller report on organization of the American Medical Association, and reached decisions on ten specific recommendations:

The office of Vice-President will be continued as an elective office; The offices of Secretary and Treasurer will be combined into one office to be known as Secretary-Treasurer, and that officer will be selected by the Board of Trustees from one of its members; The duties of the Secretary-Treasurer will be separated from those of the Executive Vice-President; The office of General Manager will be discontinued and the new office of Executive Vice-President will be established, the latter appointed by the Board of Trustees, will be the

chief Staff executive of the Association; The Council on Medical Education in Hospitals and the Council on Medical Service will continue as Standing Committees of the House of Delegates but their administrative direction will be vested in the Executive Vice-President; The voting members of the Board of Trustees will be limited to eleven, the nine elected Trustees, the President and the President-elect. The Vice-President, the Speaker and Vice-speaker to the House of Delegates will attend all Board meetings, including Executive Sessions with the right of discussion but without the right to vote; The House disapproved of the proposal to elect a Trustee from each of nine physician population regions; The office of Assistant Secretary will be discontinued, and a new office, that of Executive Assistant Vice-President, will be established; The Committee on Federal Medicine will be retained as a Committee of the Council on Medical Service and will not become a part of the Council on National Defense; The Speaker of the House will appoint a joint and continuing Committee of six members, three from the Board of Trustees and three from the House to redefine the central concept of American Medical Association objectives and basic programs, consider the placing of great emphasis on scientific activities, take the lead in creating more cohesion among national Medical Societies and study socio-economic problems.

Finally, the House condemned the Forand Bill as undesirable legislation, approved the firm position taken in opposition to it, and expressed satisfaction that the Board of Trustees has appointed a special "task-force" which is taking action to defeat the bill. In related action, giving strong approval to Dr. Allman's address at the opening session, the House adopted a statement which read:

"It is particularly timely that our President has so fortunately sounded the clarion call to the entire profession for emergency action. With complete unity, definition and singleness of purpose, closing ranks with all age groups and elements of our organization, we must at this time stand and be counted. Thus we can exert the physician's influence in every possible direction against invasion of our basic American liberties in the form of proposed legislation allegedly to compulsorily insure one segment of the population against hazards at the expense of all".

The American Medical Association, meeting in San Francisco in late June, proved again that American medicine carries on its business in a democratic manner and reaches its decisions after full and free debate. The meeting was well attended and the scientific and technical aspects of the program were enthusiastically received. The new "mole-hill" exhibit area just completed under San Francisco's City Civic Center, provided space and accommodations which received universal acclaim by both physicians and registered guests.

On the business side, the House of Delegates considered seventy-two resolutions which covered a wide scope of topics.

Among the more torrid propositions for the House was a demand for immediate action on two resolutions adopted last December. One of these resolutions called for the American Medical Association to initiate discussions with third parties representing patients, for the purpose of developing principles governing the dealings of third parties with members of the medical profession. The other proposed a program of public education on the advantages of free choice of physician by the patient. Both resolutions were aimed at the Medical Care

Plan of the United Mine Workers of North America, which, as administrator of a large fund for medical care of its members, has embraced a policy of selecting panel physicians from the various areas in which it operates.

The Board of Trustees of the American Medical Association asked the Commission on Medical Care Plans to study the December resolutions and their backgrounds and report back their findings and recommendations.

The new resolution introduced by various State delegations at the June meeting demanded immediate action to carry out the purpose of the resolution passed in December. The Reference Committee recommended deferring action until the Commission's report was made, however, it was believed that the report would contain recommendations regarding relation of physician, patients and third parties, which would better define the area of action. However, the House of Delegates over-rode the action of the Reference Committee's report and directed the American Medical Association's staff to begin instantly to carry out the programs in question.

Seven separate resolutions on Social Security went through the mill in the House of Delegates, three of them calling for a referendum of American Medical Association members on compulsory inclusion of physicians under the Social Security laws, two calling for such compulsory inclusion, and one asking for a state referendum regarding Social Security. All of these were defeated, the House of Delegates voting that any poll to be taken should be carried out by those states desiring such action, the results being transmitted to the American Medical Association delegates from the polling state. It was pointed out that the American Medical Association makes no provision in its by-laws for polls or referendums of the membership and its policy-making prerogatives lie in the House of Delegates, whose powers should not be usurped.

Regarding the Veterans Administration, the House noted the expenditure of more than \$619,000,000 for hospitalized care of veterans in 1957, and suggested that vast economies could result from restricting the admission of veterans to those who had service-connected illnesses. About three-quarters of the current admissions are nonservice-connected disabilities. The House also urged that the Dean's Committee limit its activities in Veterans Administration hospitals to those admitting only patients for service-connected disease.

The House also considered the Medicare program and voted down a proposal that repeal of Public Law #569 should be sought. Instead, it was noted that the individual state should determine with Medicare administrators the type of contract they wish. It was also voted to reaffirm an earlier decision that this legislation does not require fixed fee schedules but that physicians should be permitted to charge their usual fee for Medicare cases, in the interests of economy of administration and maintenance of orderly economics in medical practice.

On the subject of raising and distributing funds for voluntary health organizations, the House reiterated its commendation of these agencies, recognized their right to be free to conduct their own programs of research, education and fund-raising, and urged the American Medical Research Foundation to take no steps to endanger the structure of activities of the national voluntary health agency.

The House noted the Council on Mental Health on a report on "Medical Use of Hypnosis" and approved the Council action. It recommended that the report be published in the Journal of the American Medical Association with bibliography attached. In summary, the report stated that the general practitioners, medical specialists and dentists might find hypnosis valuable as a therapeutic adjunct, but in the specific field of their professional confidence. It suggests, however, that all of those who use hypnosis need to be aware of the complex nature of the phenomenon involved. Teaching related to hypnosis should be under responsible medical or dental direction, the report emphasized, and should include indications and limitations for its use. The report urged physicians and dentists to participate in high-level research on hypnosis, and it vigorously condemned hypnosis for entertainment purposes.

In a large group of miscellaneous actions, the House condemned objectional advertising of over-the-counter medicines; Adopted the amendments to the constitution and by-laws which eliminate the separate offices of Secretary and Treasurer, combining them into one, and which changed the title of the General Manager and Assistant General Manager to Executive Vice-President and Assistant Executive Vice-President; Recommended appointment of a Committee on Atomic Medicine and Ionization and Radiation and suggested that it concern itself with informing the American public on all phases of radiation and hazards related to national health; Approved in principle the admission of the Virgin Islands Medical Society as a constituent society of the American Medical Association.

In the well-appointed ballroom of the Palace Hotel, Dr. Gunderson, of La Crosse, Wisconsin, was inaugurated President of the Association. Dr. Gunderson, who is a general surgeon, had been a member of the Board of Trustees and more recently its Chairman. He is well informed, personable, and a dedicated officer, and the members can be assured of genuine leadership during his tenure. Dr. David Allman, retiring President, from our neighboring state of New Jersey, was complimented for the wisdom, intelligence and energy he displayed during his Presidency.

In elections climaxing the session, Dr. Louis W. Orr, urologist from Orlando, Florida was chosen President-elect. Dr. W. Linwood Ball, of Richmond, Virginia was elected Vice-President. Dr. Vincent Peskey of Los Angeles, was re-elected Speaker and Dr. Norman A. Welsh of Boston, Vice-speaker.

I would again urge our members when attending the interim or the annual session to spend at least a part of their time observing the actions of their House of Delegates. This is your policy-making body and you have a right to appear at Reference Committee meetings and express your opinion and views on any matters which are being acted upon. The House membership not only hopes for, but expects your advice and counsel on matters that are important to organized medicine and the American public. You should avail yourself of this opportunity to express your views.

Finally, I want to express my gratitude to the membership of this House, for the privilege of representing our State Society to this organizational element of the American Medical Association.

H. T. McGuire, M.D., Delegate

**REPORT OF REPRESENTATIVE TO  
DELAWARE ACADEMY OF MEDICINE**

To the Officers and Fellows of the  
Medical Society of Delaware:

It is with considerable pleasure that I report that the Building Fund Committee of the Delaware Academy of Medicine was successful in its efforts to obtain funds with which to proceed with the building program of the Academy.

The Chairman of that Committee was Lewis B. Flinn. His report of August 29, 1958 was as follows:

PROFESSIONAL CONTRIBUTIONS	
224 personal contributions	
(a) cash .....	\$18,133.00
(b) pledged .....	11,845.00
	<hr/> 29,978.00
5 organizations	
(a) cash .....	3,525.00
(b) pledged .....	14,000.00
	<hr/> 17,525.00
	<hr/> 47,503.00
LAY CONTRIBUTIONS	
208 personal contributions	
(a) cash .....	212,852.87
(b) securities .....	31,139.00
(c) pledged .....	10,290.00
	<hr/> 254,281.87
Less contributions designated for operating fund .....	301,784.00
	<hr/> 1,955.00
<b>TOTAL FOR BUILDING FUND</b>	<b>\$299,829.87</b>

The medical profession in Delaware has reason to be grateful to its lay friends for this substantial evidence of their confidence and esteem.

Ground has been broken for the new building and we have reason to hope that it will be ready for dedication at the time of or the day before the next Annual Meeting of the Medical Society of Delaware.

The buildings, new and old, have been designed so as to provide office space for the Academy, the New Castle County Medical Society and the Medical Society of Delaware. Additional office space is available for the use of private health agencies. In addition to the present auditorium there will be one seating up to 300 persons and another room of similar size for the use of exhibitors at meetings of our state society. Space for enlarged library facilities has been provided for.

A vote of thanks for a task well done is due the officers of the Academy as well as the Building Fund Committee and its chairman.

The more than generous contributions by our lay friends have made possible the realization of a dream long held by the medical profession of Delaware. Our appreciation and gratitude may be made manifest only by the continued devotion of physicians and kindred professions to the service of mankind, physically and socially.

The Academy has continued its program of education of the public in matters pertaining to the health of individuals. The Academy, with the invaluable assistance of the News-Journal newspapers, the Group Hospital Service, and the Welfare Council of Delaware, has conducted the 6th Annual Series of Public Health Forums. The

speakers, authorities in their special fields, have spoken on such topics as "Combatting the Crippler, Arthritis," "Cancer, the Problem and the Promise," "What's New for the Diabetic?" "Treating Your Itches, Rashes, and Eruptions," and "The Turning Point in Mental Health." These Forums have, in general, been well attended.

The Academy has continued its interest and active support of those programs having to do with the Delaware Bar Association, the clergy, and community affairs, as they concern the health of the people.

Respectfully submitted,  
VICTOR D. WASHBURN, M.D.  
*Representative to the  
Delaware Academy of Medicine*

**CANCER REPORT FOR 1957-1958**

As liaison officer of the Medical Society of Delaware and the Delaware Division of the American Cancer Society, I would like to present the following report for the year 1957-1958:

Through the Delaware Professional Education Program, physicians, dentists, nurses, etc. were kept informed of the latest developments in clinical cancer. This was done through the magazine, CANCER, a bulletin of cancer progress, films and slides. The Society also arranged cancer programs for the State Nurses and State Medical meetings as well as the Academy of General Practice.

The Cytology program is also being promoted. At the present time, a new way of cataloging and follow-up visit is being instituted for the benefit of patients.

In May, 1958, a physician was employed to review, analyze, and evaluate the statistical studies of cancer in Delaware through coordination of the figures available from the tumor registry of each hospital and from the State Board of Health.

Two thousand, two hundred and five patients were examined from September 1, 1957, to August 31, 1958, in 159 detection centers. There were 718 referrals to physicians with 663 of these being to rule out cancer. Three cases of cancer were detected during this period of time—bringing to 100 the number of cases discovered during the period from March, 1948, to the present time.

By February 1, 1959, the Cancer Society expects to end its detection center activity. It is expected that the physicians and the hospitals themselves will take up this phase and make a reality of the phrase—"Each doctors' office a detection center." The hospitals and physicians will be furnished free of charge a notification and follow-up system so that patients will have time to make regular appointments. This will be done by means of a tickler system that will automatically bring up a patient's name at regular intervals and allow time for the patient to be notified. The patient can then make an appointment with the physician of her choice.

Respectfully submitted,  
OSCAR N. STERN, M.D.

**REPORT ON THE ACTIVITIES OF THE  
DELAWARE HEART ASSOCIATION 1957-58**

As liaison agent between the Medical Society of Delaware and the Delaware Heart Association, I wish to report the following list of regular services that have taken place in the State of Delaware, and will continue to take place throughout the years 1958 and 1959.

1. CARDIAC CAMP: Planning and arranging for camp for indigent cardiac children. There were 25 children who attended camp the summer of 1957; this year there were 35 children who benefited from this program.

2. CARDIAC REHABILITATION PROGRAM: Develop plan to prepare a program for restoring cardiacs to gainful employment; conducted a survey of case load.

3. RESEARCH COMMITTEE: Develop and administer policies pertaining to research; granted funds for three projects in Delaware.

4. NURSES' SEMINAR: To further educate the nurses throughout the state.

5. Administered and supervised two clinics for the care of indigent patients.

6. Provided oxygen equipment and wheelchairs to homebound cardiac patients.

7. Provided eminent cardiologist for the annual meeting to better educate the public. This cardiologist also addressed the monthly meeting of the New Castle County Medical Society.

8. Provided literature and pamphlets to better educate the public.

9. Added to the cardiac library at the Academy of Medicine for better proficiency of doctors.

10. Developed interest and supplied film based on resuscitation for cardiac arrest, for better medical proficiency.

11. Provided visual aids, such as heart models, films and film slides to hospital staffs, nurses in training and practical nurses.

12. Developed a Committee which includes representatives of other agencies in the field of Rehabilitation throughout the state, to set up the "Work Classification Unit".

13. Recruited blood donors for patients undergoing heart surgery.

14. Sponsored surgical treatment and catheterization studies for the indigent of the state.

In the year 1958-1959, several projects are under discussion, such as the following:

1. Investigate the feasibility and need for "throat culture" handling for the medical profession, so that prompt reports can be given to physicians, and so that indigent patients may have the benefit of such a program.

2. A statewide rheumatic fever prophylaxis program, so that no child or adult in the state needing this treatment will be denied it.

3. Establishment of a Screening Clinic for heart cases in the down-state area, with Dr. Harry Zinsen in attendance, the location of which is to be determined at a later date after full discussion with all interested parties.

Respectfully submitted,  
EDWARD M. KRIEGER, M.D.

#### LIAISON WITH MENTAL HEALTH ACTIVITIES

During the fiscal year 1957-1958 several significant achievements in mental health were accomplished in the State of Delaware. Outstanding among these achievements has been the establishment of expanded preventive and treatment facilities. It has long been our philosophy that more people can be helped with greater effectiveness if facilities are available in their localities.

In line with this philosophy the program of the Mental Hygiene Clinic has been extended to include a clinic in Sussex County at Stockley, Delaware, to serve Kent and Sussex Counties. With the establishment of this clinic preventive outpatient psychiatric service at State expense has been provided in all three counties at a much more effective and more extensive level than was possible previously. The Stockley Clinic was held during the year on an average of two days a week. The number of patients receiving service has been between ten and twenty-eight with from five to sixteen in psychotherapy.

Another activity of importance and of interest to the community has been the opening of the so-called State Day Care Centers for Severely Retarded Children. These are children with I. Q. less than 30 whose parents are eager to have them remain at home rather than to seek residential care for them. The program began with the opening of the Day Care Center at Georgetown, Delaware, on February 3, 1958. Six children are receiving daily care in this facility. On March 27th, the Dover Day Care Center began service, with five children enrolled. The third and largest center is in Wilmington. It opened on April 28th with 21 children and has had a constant enrollment of twenty. The most recently opened center is at Seaford. On June 25th it began providing care for four children.

These centers are under the general supervision of the Superintendent of the three State psychiatric institutions and the immediate supervision of a well-qualified person, Dr. Charles Jubenville. A total of thirty-six children has received care in these centers. Families have received assistance in the burden of constant care of their severely retarded children. According to the reports from parents and the center workers as well, the children have shown general improvement in socializing activities and in getting along with others. Progress in habit training has been made by some. In several children lengthened attention spans have been noted.

At the Delaware State Hospital before the close of the fiscal the open ward or Social Therapy program was intensified and expanded. Sussex Hall, formerly housing staff members, was completely renovated and made available for the use of patients included in this program. Under this plan of therapy male and female patients are prepared for return to the community by participating in activities, including work, which are a part of extramural life and by experiencing greater freedom of movement around the premises. There are now seven open wards, providing for approximately 265 patients experiences which should facilitate their recovery and return to the community.

The renovation and modernization of several of the units of the State Hospital has provided greatly improved facilities for the care and treatment of the patients. The Medical-Surgical Division was opened in modernized and redecorated premises. This service is under the supervision of a staff of internists of which Dr. Ward Briggs is the Chief. Patients newly admitted for treatment enter the Hospital through modern receiving wards.

Nearing completion is the new acute and convalescent unit. This one-story structure, built at a total cost of \$1,575,000.00, will provide in wards of one, two, and four-bed rooms facilities for 175 mentally ill patients in the acute or convalescent phase of the illness. The building is designed with a music room, an occupational therapy room, and a multi-purpose room which can be used as an auditorium, gymnasium or conference room. The

sum of \$110,000.00 has been allocated for furnishings. Mentally ill patients receiving intensive treatment in attractive home-like surroundings during the acute stage of their illness may be helped to recover more rapidly than was possible in the formalized institutional atmosphere traditionally provided.

Through the co-operation of the Office of Vocational Rehabilitation, The State Mental Health Association and the Delaware State Hospital vocational rehabilitation service has become available to patients while they are convalescent and in preparation for trial visit and discharge. During the past fiscal year 117 patients were referred to the Vocational Rehabilitation Unit. Of this number 87 were accepted for service, 31 were employed and were ready for employment but not yet placed. There were 30 still in training at the end of the year. The program included two classes each of home economic and woodshop classes. Plans were completed to add to the program early in the next fiscal year classes in clerical work.

The Drug Therapy Home Care Program was instituted and has continued to make possible the care of selected patients at home. A registered nurse supervises the patients, reporting to the Clinical Director their condition as well as the mutual relationships of the families and the patients. She also gives to members of the family instruction on the management of the patient and the administration of the medication. There have been 103 patients involved in this program to date.

Education in mental health was given great impetus during the past fiscal year through several projects of the Mental Health Association of Delaware. The Symposium for the Medical Profession held at the A. I. du Pont Institute on April 12, 1958, was well attended and well received. A Workshop for Clergy was sponsored by the Field Services Committee of this organization. Two sessions were held in April and two in May. Delaware clergymen were sent several issues of "Pastoral Psychology."

The Mental Health Association of Delaware in co-operation with the Delaware Chapter of the American Academy of General Practice and the United States Public Health Service, made plans for a post graduate course in Psychiatry for the Family Physician. The program is planned for ten sessions to be held in successive weeks from September 17 through November 19, 1958. The discussions are to be on such pertinent psychiatric problems as danger signals of depressions and potential suicides, the uses and misuses of certain types of drugs, the management of the acute psychotic, alcoholism and drug addiction, geriatric patients, pediatric and adolescent psychiatric problems, the diagnosis and managements of paranoia and the psychopath, and several related problems.

Mental Health Week was observed in Delaware from April 27-May 5, 1958, under the sponsorship of the Mental Health Association of Delaware, the three State psychiatric institutions, and various social agencies and institutions in the State. The program included Open House at the Hospital for the Mentally Retarded at Stockley, a symposium at the University of Delaware, the annual Meeting and luncheon of the Mental Health Association, and the Delaware Mental Health Forum. Dr. Jack Ewalt, the commissioner of Mental Health of the Commonwealth of Massachusetts, brought to the large number of luncheon participants a preliminary report of the activities of the Joint Commission on Mental Illness and Health, of which he is the executive director. Dr. William Menninger of the Menninger Clinic at Topeka,

Kansas, was the speaker for the Delaware Mental Health Forum.

Progress in mental health in Delaware continues to be made, although slowly in some areas. The need is still great, however, for improved programs and facilities as well as for increased professional personnel to serve the Delaware citizens who are in need of help to prevent or recover from mental illness. The combined efforts of physicians, educators, clergy, legislators, the judiciary, and members of families must be mobilized to insure adequate facilities and services for the growing numbers of the mentally ill and emotionally disturbed whose problems are of serious proportions. We cannot rest until all who need help for their problems can obtain such help speedily and effectively.

M. A. TARUMIANZ, M.D.

The Delaware Anti-Tuberculosis Society has continued its state-wide program during the year. Its case finding program included cooperation with the State Board of Health in operating two mobile X-ray units. This program last year reached more than 62,000 Delawareans. X-raying was continued in the offices of the Society for food handlers, patients referred by private physicians and teaching personnel. The Society assisted the Rehabilitation Division in its program. The case finding program for migratory workers was carried on during the summer in cooperation with the United States Public Health Service and the State Board of Health.

The Society during the year approved a grant to the Delaware Academy of Medicine to assist the Academy in expanding its educational and research program. Approval was given by the Society to provide for the establishment of an annual lecture on chest diseases with the Society to assume the obligation involved in the promotion of this annual event.

GERALD A. BEATTY, M.D.

#### REPORT OF LIAISON COMMITTEE WITH VOCATIONAL REHABILITATION

The Committee had no formal meeting this year. However, matters of common interest were discussed with John G. King, Director of Vocational Rehabilitation.

There has been a steady growth in the number of cases handled by Vocational Rehabilitation, with an all time peak of 490 in the fiscal year of 1958 compared with 16 in 1940, the first year in which this service was available to residents of the State of Delaware. As usual the demands for funds has exceeded the amount of money allotted for this purpose and during the last 4 months of the fiscal year, very little money was available.

Of considerable concern to the State of Delaware, is the 1954 Vocational Rehabilitation Amendments which introduced an allotment formula based on need as measured by States population and per capita income. Delaware being a high income, low population state will be seriously affected by this formula.

Starting in 1960, Federal funds allotted to Delaware will decrease \$13,000 a year, continuing for 4 years so that by 1963 our Federal allotment will be \$52,588 less than at present. If the Vocational Rehabilitation Service is to be available to our State's citizens in the future as it has been in the past, this will mean funds will have to be forthcoming from the State. Assuming the unlikely possibility that there will be no need for a larger budget in 1963, this will mean that half of the

total budget of approximately \$250,000 must be supplied by the State.

Included in this amount was approximately \$18,431 paid to physicians in Delaware for examinations, \$34,867 for surgery and treatment, and \$28,439 for hospitalization.

The Committee does not feel any action should be taken but feels that we should be aware of what is going on in this field and render any assistance when called upon to do so.

Respectfully submitted,  
S. WARD CASSCELLS, M.D.

**REPORT OF THE COMMITTEE  
ON NOMINATIONS**

Your committee presents the following nominees for officers and standing committees of this Society for 1959.

For:  
Vice President ..... Daniel J. Preston  
Secretary ..... Norman L. Cannon  
Treasurer ..... Charles Levy  
Representative to the Delaware Academy of Medicine ..... Victor D. Washburn

**COMMITTEE OF BUDGET**  
Charles Levy  
M. A. Tarumianz  
W. C. Pritchard, Jr.  
T. H. Pennock  
Felix Mick

**COMMITTEE ON MEDICAL EDUCATION**  
Lewis B. Flinn  
Laurence L. Fitchett  
G. Barrett Heckler

**COMMITTEE ON PUBLIC LAWS**  
Wm. O. LaMotte, Jr.  
James Beebe, Jr.  
J. Leland Fox  
J. S. McDaniel, Sr.  
Gerald A. Beatty

**COMMITTEE ON SCIENTIFIC WORK**  
James T. Metzger, Chairman  
Joseph B. Elliott, Laurel  
Norman L. Cannon

**COMMITTEE ON NOMINATIONS**  
Robert W. Frelick  
James B. Homan  
John W. Alden, Jr.  
J. Stites McDaniel

**NOMINEES TO THE STATE BOARD OF MEDICAL EXAMINERS**

Charles E. Maroney  
David N. Sills, Jr.  
Ward W. Briggs  
Norman L. Cannon  
Arthur J. Heather  
G. Barrett Heckler  
Leslie W. Whitney  
Harold A. Tarrant  
A. Henry Clagett  
Philip D. Gordy

Respectfully submitted,  
LESLIE M. DOBSON, M.D.  
Chairman

PRESIDENT BAKER: Now we have items of new business coming before the House. Under this we have some resolutions. Will you read those?

DR. CANNON: First, the Council has recommended to the House of Delegates that the bylaws be changed to permit the delegate to the A.M.A. to become a voting member of the Council. The reasons for this are pretty obvious. The delegate to the A.M.A. is our liaison and brings back a

lot of information, and we felt that the Council should have him as a member. This requires an amendment to the bylaws, Article VII, Section 2, adding the words "and the delegate to the A.M.A." It will read that the Council will consist of the representatives from the counties of Kent, New Castle and Sussex, President, Secretary, Treasurer and the delegate to the A.M.A. We would like you to vote on that amendment. And this will have to be read twice, by the way. The second reading has to be at the meeting next Thursday.

DR. CASSELLA: Does a motion have to be made?

DR. CANNON: A motion will have to be made. The Council recommends it.

DR. CASSELLA: I make a motion that that phrase be included.

(The motion was seconded.)

PRESIDENT BAKER: All in favor say "Aye".

(The motion was carried.)

PRESIDENT BAKER: We have another resolution.

DR. CANNON: The Council recommends to the House of Delegates that the office of the Medical Society of Delaware be moved to the Delaware Academy of Medicine upon completion of construction of the Academy's new wing providing that a rent acceptable to both the Society and the Academy can be agreed upon.

PRESIDENT BAKER: You have heard the reading of this resolution. Do I hear a motion that it be accepted?

(A motion was made and seconded.)

PRESIDENT BAKER: All those in favor say "Aye".

(The motion was carried.)

PRESIDENT BAKER: We have another resolution.

DR. CANNON: I would like to preface this a little bit. The House of Delegates had voted an annual contribution to the Academy of Medicine of \$1,000 a year. The Council had recommended during the year that the Medical Society of Delaware contribute \$10,000 to the building fund of the Academy. That was a large sum of money for the Council to spend, especially since it is your money, and we would like to recommend that this contribution be official by the House of Delegates but that the yearly contributions to the Academy be discontinued. We will be paying rent, more rent than we are paying now, and we felt that a \$10,000 contribution plus the rental would be more desirable than continuing this annual contribution.

PRESIDENT BAKER: You have heard the resolution as read. Do I hear a motion that we accept it?

(A motion was made and seconded.)

PRESIDENT BAKER: All those in favor say "Aye".

(The motion was carried.)

DR. CANNON: We have obtained as legal counsel for the Society David Anderson, and he has provided us with a lot of service during the past year, and the Council voted to present him with an honorarium of \$200, which represented the funds that had been allocated to the Committee on Public Laws. They did not use the \$200, and we sent a check to Mr. Anderson as an honorarium in that amount.

He sent us a nice letter and the check back thanking us very much for the idea, but he declined the honorarium, and we would like a resolution passed by the House of Delegates that it express its sincere thanks and appreciation to Mr. David F. Anderson, counsel to the Medical So-

society of Delaware, for services during the past year.

(A motion was made and seconded.)

PRESIDENT BAKER: All those in favor say "Aye".  
(The motion was carried.)

PRESIDENT BAKER: Next we have communications. We have one from the Delaware State Pathology Society.

September 16, 1958

Medical Society of Delaware  
c/o Mr. Lawrence C. Morris  
621 Delaware Avenue  
Wilmington, Delaware

In recent years the Delaware State Board of Health has been extending free coverage for physicians' private patients for cytological examinations of fluids and secretions from the body. We believe this service to indigent patients is commendable, however, such a coverage has always been provided by the pathologists of the state on request. We do not believe that such use of tax money for private patients is desirable as long as there is private physician coverage in all of the pathology laboratories in the state.

We therefore recommend that the State Medical Society suggest to the State Board of Health and organizations concerned with their activities that the State Laboratory offer free cytological diagnoses to indigent patient *only* and that the physicians of the state society be encouraged to utilize the facilities of their associates, the pathologists, throughout the state.

For the  
Delaware State Pathology Society  
JOHN W. HOWARD, M.D., President  
JOSEPH W. ABBISS, Councilor

cc: Dr. Harold A. Tarrant

FROM THE FLOOR: Does that apply to the Papanicolaou smears we were talking about?

DR. ABBISS: That is right.

DR. HUDSON: I would like the privilege of the floor for a minute. I would like to cite the history of this thing.

I just found out this was going to be taken up, on Friday, and I called the medical members of the board, the ones I could get. They asked me to remind the Society that this was begun because of the interest of practitioners asking the Board of Health if they could not do this service for them. The matter came up before the New Castle County Medical Society with your pathology group presenting these same arguments about seven years ago, and the Society at that time asked the State Board of Health to go on and provide this service for private physicians.

Now, the Board has instructed me, or the members that I contacted — this is not an official action of the board — that the Board of Health does not wish to get any phase that is properly that of private practitioners. If the pathologists in the State can handle this situation and do a good job, they are perfectly willing to drop the whole thing and let them carry it. It is up to the Society as to what the Board of Health will do, whatever you pass here. However, the members of the board to whom I talked asked me to point out that Cancer is a pretty large problem and a public health problem and that the Board could not in all truth get out of the Cancer business entirely from a case finding and early finding of cases point of view.

The Board, I believe, considers that these Papanicolaou smears are part of a case finding pro-

gram. We do not enter into any actual diagnosis, or treatment of these cases. These are referred back to the private physicians.

However, whatever the Society wishes the Board of Health to do, they will try to carry it out.

DR. WASHBURN: May I speak to that, Mr. President?

As you may or may not recall or be aware, the Delaware division of the American Cancer Society has recently changed its policy, discontinuing the policy which has been in operation for several years of conducting cancer detection centers, and in connection with that decision to discontinue those centers and to emphasize the importance or the fact that the proper place for the detection of cancer was in the office of the members of the medical profession, I addressed a letter to each of the four hospitals in Wilmington asking if they would be willing to establish cancer detection programs in the out-patient departments of those hospitals in Wilmington for indigent patients. At a meeting of the Staff Executive Committee of the Memorial Hospital held within the last few days the Committee voted to authorize or request that the gynecological service in the out-patient department be authorized and requested to pick up the cases that might be referred as indigent patients, but they would be subject to scrutiny or to screening to which all out-patient clinics are subjected, as to their financial status, the theory being that we are prepared to take care of the medically indigent, and I thought this was important made so far as the Delaware division is concerned to provide a means of caring for the medically indigent in cancer detection in the City of Wilmington.

PRESIDENT BAKER: Is there any further discussion?

DR. LAYTON: Mr. President, I object to the fact that the pathologists want the State Board to take over the indigent patient because they want to continue in the private practice, their field. Why don't they also take on like the rest of us the indigent patient? Most of the pathologists have a salary and work on a salary or commission basis and their living is assured. Why can't they do it for the indigent just as well?

DR. ABBISS: I think if you read that more carefully, it says we do take care of indigent patients for nothing. We always bring that point out. The letter so states.

DR. CANNON: We believe this service to the indigent patient is commendable. However, such a service is always covered by the pathologists.

DR. HUDSON: The load of slides that come in, actually this year we will have in the neighborhood of 1,000 a month, a little over 12,000 slides at the end of the year to examine, if it continues as it has in the past few months. It takes, say, 15 or 20 minutes for the average technician, each one. Maybe a pathologist can do it faster, I don't know, but it takes that long to screen an individual slide, and that is a pretty big load. If that load continues to go from the private physicians to the pathologists, it is a pretty big load to assume, even for the pathologists we have in the State. I mean, there are only about five or six, aren't there?

DR. ABBISS: Ten.

DR. HUDSON: That is not too bad. It will give them one thousand apiece.

PRESIDENT BAKER: Well, you have heard the discussion and you have heard the letter read.

DR. CANNON: May I just read that the Delaware State Pathology Society recommends that the State Society suggest to the State Board of Health and organizations concerned with their activity that the State Laboratory offer free cytological tests to indigent patients only and that the physicians of the State Society be encouraged to use the facilities of their associates, the pathologists, throughout the State.

DR. GLIWA: I don't think that the State Board of Health should be saddled with the responsibility of determining indigency on these slides that are coming in. I think it is up to the practicing physician. If he feels he wants the State Board of Health to do it, of course the State Board of Health would probably do it, but I don't think the State Board should determine indigency, that it is up to each individual practicing physician.

DR. ABBISS: We prefer to do them without dealings all throughout the State.

DR. MCGUIRE: May I just come back to some fundamentals, if I may be so imprudent, and that is this: Here we are again coming back to the State and asking for things. We have been asking too long, and this is a fundamental thing that we are constantly asking for, freedom of choice, freedom of action, free medicine, and so on. We started when Dr. Hudson was younger and I was younger, when the only thing the State Board of Health handled was syphilis, gonorrhea and the inner tuberculosis patient. Since then we have gotten into Lord knows how many areas.

This comes back to the fundamental thesis, are we supposed to give something in the practice of medicine every once in a while? I know our current view is that a doctor is supposed to be paid for everything he does. If that is so, then my philosophy is wrong. I think the pathologists should share in doing free work the same as everybody else, and I think this comes back to the fundamental philosophy of the invasion and the requesting on the one hand of the State to do more and complaining on the other hand because taxes are so high. We have gotten ourselves in a very vulnerable position, as to this business of the viral laboratory, which I would be brave enough to predict that will be one of the big problems in medical practice within the next ten years, are we going to the State and ask for it or are we going to do it by the public, private enterprise practice of medicine.

So this comes back to—I agree with Dr. Gliwa that the State Board of Health should not determine indigency. I also agree that the pathologist has as much a right to do something for nothing as I have to go see a baby with measles. So this again comes back to the thing that happened in Britain, that happened in Scandinavia and Italy and all the other places, that eventually they kept asking for more and more. Of course this letter says, private patients. So the responsibility lies with the individual fellow who knows his patient better than anybody else as to their indigency. But I would hope that somewhere along the line we would get some consistency about these things. We are complaining on the one hand and grasping on the other.

DR. POLLAK: The cleavage is quite clear to me. The State Board of Health has cancer clinics, cancer clinics in New Castle, Kent and Sussex Counties, and they do not ask if the patient is indigent or can pay. These smears go to the State Board, and I suppose they should go in the future as long as the State Board of Health has these clinics.

Smears from the private physicians, from his office are a horse of another color. There a

physician can determine whether a patient can pay or not, and all these smears should go to the pathologist with the proper comment that a patient can pay for it or that the patient is indigent. And I am sure that the pathologist can cope with it.

But the situation is becoming more complicated, and will become more so. As Dr. Washburn pointed out, by February 1st the Cancer Society in Wilmington is going out of business as far as the clinics are concerned. Now the indigent patients I presume will go to hospitals and the pathologists will get all those smears, free smears. But the smears from private offices will go to the Board of Health.

The way the Board of Health has difficulties with personnel—and maybe I shouldn't speak about it, but as long as we are laying the cards on the table, I will lay them on the table—only last week I got a phone call from the State Board of Health, whether I would look at 400 slides for Dr. Capana, and I know that other men of our Society had the same request. And the number of slides will increase in the future, and it will become more and more difficult for the State Board of Health to cope with.

So I think it would be to the mutual advantage of everyone if this would be solved in the direction of the pathologists, as has been suggested.

DR. HUDSON: I would like to speak off the record. (Dr. Hudson then spoke off the record.)

DR. BAKER: If there is no further discussion, we have before us the recommendation in the letter, or, if you have an alternative, please suggest it. If not, we will accept a motion.

DR. HALL: I think it should be pointed out that if this is accepted and we decide that all these should go to the pathologist, we are not going to handle that many, our case finding is going to drop very considerably and cancer is going to increase, so that when a patient comes into your office, you can get a serology for them, a cancer summary, in addition to a complete physical and a history, you have to worry about whether you can pass by a chest x-ray and some of these things that are supported.

I think the important point here is whether we are going to decrease our case finding by this, and I think the answer is yes, that if we charge these people five dollars apiece, many of us who do it routinely are going to stop doing it routinely because we have to consider the patient's pocketbook as well as their future welfare. The pick-up that I have had in four years has been two cases, and I don't know how many I have done, but it has been over 300.

DR. FRELICK: I think this is an important point. I think it is unfortunate in some respects that this has come up when the American Cancer Society is trying to get to this change-over. I think in time this will take care of itself. I think that as patients and physicians understand that they can get better and more rapid service from pathologists and educate their patients in this that the patients will accept it and the physicians will accept it. I think if we try to tell the State Board of Health to go out of the service completely it is going to be difficult to persuade many of the patients, at least initially, that they should pay this extra five dollars. Many will be willing. I have conducted a personal survey the last several weeks on this, and about 70% of our patients are willing to pay the extra. Some feel they would rather not have the smear than pay this extra money. I think we have to remember that in this business of indigency it is difficult sometimes that persons may

still be able to pay an ordinary office fee and not be able to pay the five dollars extra, or be able to pay the five dollars extra and not the office fee. There are many people who don't have the extra five dollars but still are private patients and we still should have I think some leeway some place for these borderline patients, these patients who perhaps cannot afford this extra money, and I don't think we should accept this resolution in this respect, because I think time and education will take care of the problem.

DR. REARDON: I think you have a public relations problem here. People will say, the doctor has enough money now—and when we need their support when the Legislature meets down here in Dover, we don't want to have them antagonistic.

DR. WHITNEY: May I speak briefly on behalf of the American Cancer Society.

Dr. Frelick indicates there is a large program starting now until the first of the year trying to educate the public to deviate from the detection centers to the private physician's office. I think from a historical standpoint we are grateful to the Board of Health for carrying this load of cytological diagnoses when actually adequate facilities were not available elsewhere to have it done.

The American Cancer Society is anxious to provide training for cytologists to make available to the State of Delaware sufficient cytologists for screening smears. I think the time must come when this work is done, as all other private work is done, in our local institutions.

DR. WASHBURN: May I make one comment and it is this: I agree with the doctor here who speaks about this as a public relations problem, among other things, and I think that we have failed to lay emphasis upon the fact that many, many times we who are practicing medicine, there is a question as to whether this patient properly should be asked to pay both the office fee and the fee for the pathologist, that the doctor should

forego his fee, not only in terms of public relations, but in the mission that we are really engaged in, our first obligation is to find these cases of early or unsuspected malignancy, and our obligation is always there rather than in the direction of our own pocketbook.

PRESIDENT BAKER: If there is no further discussion, we have this recommendation which we can either accept, reject, or we can receive. Do I hear a motion for one or the other?

DR. HALL: I move we reject it at this time.

(The motion was seconded.)

PRESIDENT BAKER: All in favor say "Aye".

(There was a chorus of "Ayes".)

All opposed, "No".

(There was a chorus of "No's".)

PRESIDENT BAKER: That sounded about even. Shall we have a hand vote on that or shall we just go ahead and table this?

DR. CANNON: I would like to read these words again: This is a suggestion to the State Board of Health and we are encouraged to do it; this is not committing anyone to any definite course of action.

DR. HALL: May I change my motion. I move we defer any action at this time.

(The motion was seconded.)

PRESIDENT BAKER: It has been moved that we accept it without any action. All in favor say "Aye".

(The motion was carried.)

The Committees on Scientific Work, National Defense, and Hospital-Physician Relationship did not meet during the year.

The Meeting of the House of Delegates adjourned at six thirty.



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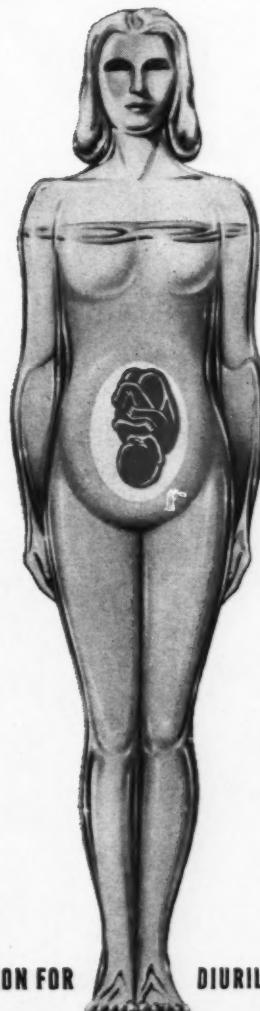
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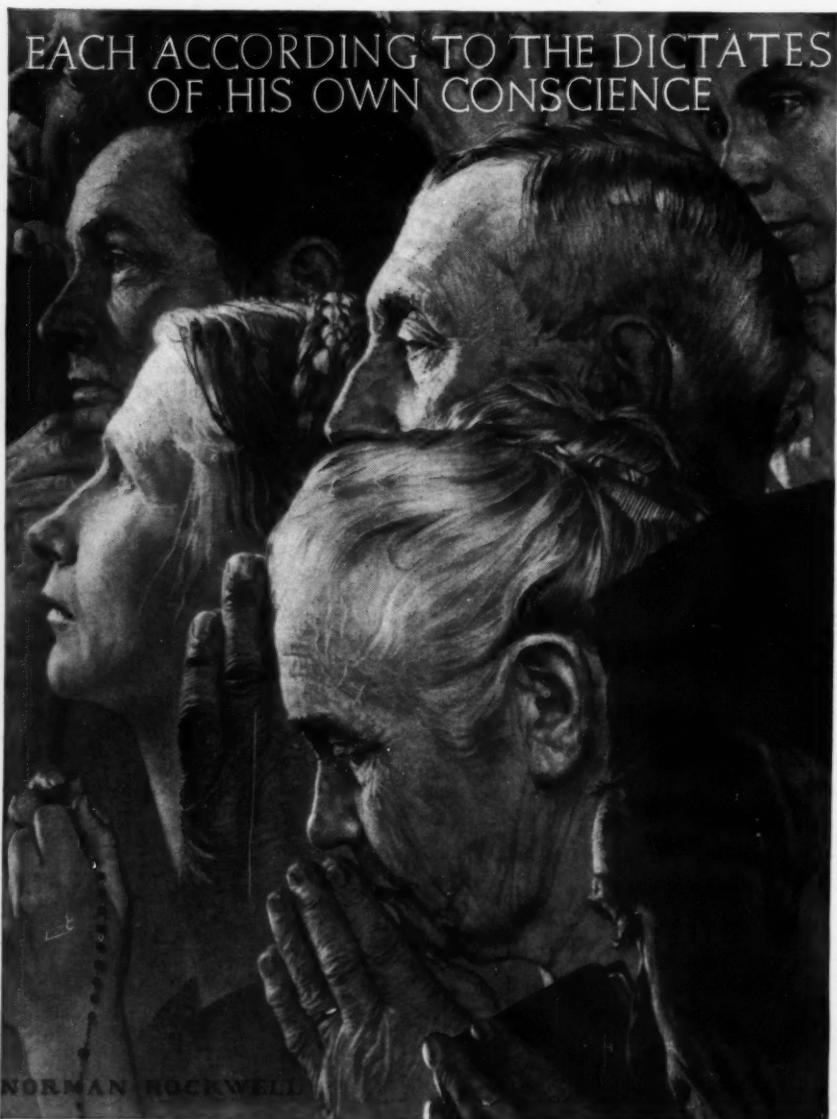
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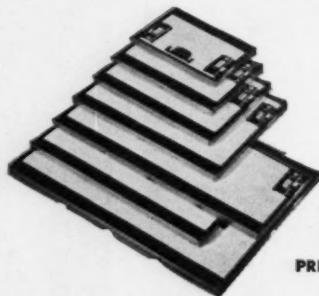
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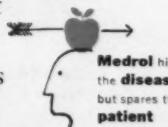
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**SUPPLIED:** Multiple Compressed Tablets in three formulas: MEPROLONE-2—2.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-1 supplies 1.0 mg. prednisolone in the same formula as MEPROLONE-2 (bottles of 100). MEPROLONE-5—5.0 mg. prednisolone, 400 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 30).



a

**Because muscles move joints, both muscle spasm and joint inflammation must be considered in treating the rheumatic-arthritic patient . . .**

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa. 

# Rheumatoid Arthritis

multiple compressed tablets

# MEPROLONE<sup>®</sup>

THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY



b

MEPROLONE is the one antirheumatic-antiarthritic that exerts a simultaneous action to relax muscles in spasm and to suppress joint inflammation...

c

Therefore, MEPROLONE does more than any single agent to help the physician shorten the time between disability and employability.



MEPROLONE is a trade-mark of Merck & Co., Inc.

**ANKLE  
SPRAINED  
OR  
SINUS  
INFLAMED?**

ACCELERATE THE  
RECOVERY  
PROCESS WITH

**VARIDAS** **BUCCAL** TABLETS

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY,  
Pearl River, New York

\*Reg. U. S. Pat. Off.

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SPRAINED  
OR  
SINUS  
INFLAMED?**

**P AR KE**

*Institutional Supplier  
Of Fine Foods*

**COFFEE TEAS  
SPICES CANNED FOODS  
FLAVORING EXTRACTS**

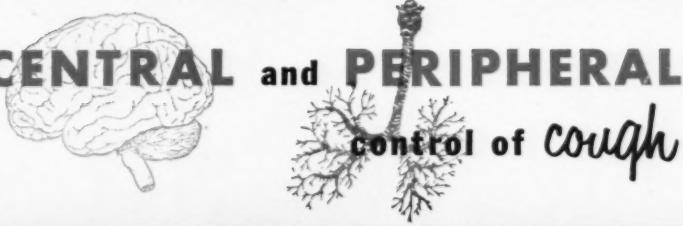
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Both **CENTRAL** and **PERIPHERAL**  
  
**control of cough**

**SYNEPHRICOL®** *cough syrup*  
 ANTITUSSIVE • DECONGESTANT • ANTIHISTAMINIC

Combines:

Central Antitussive Effect — mild, dependable  
 Topical Decongestion — prompt, prolonged  
 plus Antihistaminic and Expectorant Action

*Winthrop* LABORATORIES  
 NEW YORK 18, N. Y.

Each teaspoonful (4 cc.) contains:

Neo-Synephrine® hydrochloride	5.0 mg.
Thenadil® hydrochloride	4.0 mg.
Dihydrocodeinone bitartrate	1.33 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz.

EXEMPT NARCOTIC

Synephrine, Neo-Synephrine (brand of phenylpropanolamine), and Thenadil (brand of thenadilamine), trademarks reg. U. S. Pat. Off.

in very special cases  
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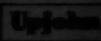
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# In potentially- serious infections...

TRADEMARK, REG. U. S. PAT. OFF.  
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TRADEMARK

The Upjohn Company, Kalamazoo, Michigan



# Make new Panalba\*

(Panmycin<sup>†</sup> Phosphate plus Albamycin<sup>\*\*</sup>)

## your broad-spectrum antibiotic of first resort

effective against more  
than 30 common pathogens,  
even including  
resistant staphylococci.

### Available Forms:

1. Panalba Capsules, bottles of 10 and 100 capsules. Each capsule contains:

Panmycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydrochloride ..... 200 mg.

Albamycin (as novobiocin sodium) ..... 125 mg.

2. Panalba KM 11 Flavored Granules. When sufficient water is added to fill the bottle, each 1/2 teaspoonful (8 cc.) contains:

Panmycin (tetracycline) equivalent to tetracycline hydrochloride ..... 125 mg.

Albamycin (as novobiocin calcium) ..... 52.5 mg.

Potassium metaphosphate ..... 100 mg.

### Dosage:

#### Panalba Capsules

Usual adult dosage is 2 capsules q.i.d.

#### Panalba KM Granules

For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 10 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.



ELECTIVE AND TRAUMATIC

use

## XYLOCAINE® HCI SOLUTION

(Brand of lidocaine\*)

as a local or topical anesthetic

Xylocaine is routinely fast, profound and well tolerated. Its extended duration insures greater postoperative comfort for the patient. Its potency and diffusibility render reinjection virtually unnecessary. It may be infiltrated through cut surfaces permitting pain-free exploration and longer suturing time.



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† warts; moles; sebaceous cysts; benign tumors; wounds; lacerations; biopsies; tying superficial varicose veins; minor rectal surgery; simple fractures; compound digital injuries (not involving tendons, nerves or bones)

\*U. S. PAT. NO. 2,441,498 MADE IN U. S. A.

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*Quality Dairy Products*  
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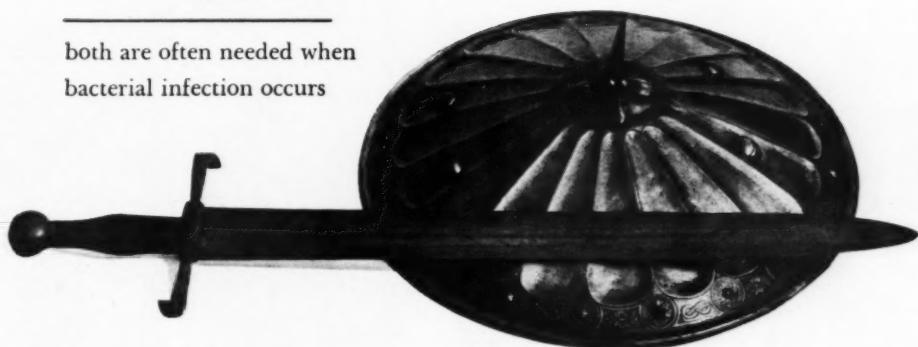
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**PATRONIZE  
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ADVERTISERS**



- prompt, aggressive antibiotic action
- a reliable defense against monilial complications

both are often needed when bacterial infection occurs



## for a direct strike at infection Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and *Endamoeba histolytica*).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

## for protection against monilial complications Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against *Candida (Monilia) albicans*.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

# MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

Capsules (250 mg./250,000 u.), bottles of 16 and 100. Half-strength Capsules (125 mg./125,000 u.), bottles of 16 and 100. Suspension (125 mg./125,000 u. per 5 cc.) 60 cc. bottles. Pediatric Drops (100 mg./100,000 u. per cc.) 10 cc. dropper bottles.



Squibb Quality — the Priceless Ingredient

\*MYSTECLIN®, \*SUMYCIN® AND \*MYCOSTATIN® ARE SQUIBB TRADEMARKS



# "Much better— thank you, doctor"

## Proven in research

1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

## And now in practice

4. More rapid clinical response
5. Unexcelled toleration

# COSA-TETRACYCYN\*

GLUCOSAMINE-POTENTIATED TETRACYCLINE

**CAPSULES**

(black and white)  
250 mg., 125 mg.  
(for pediatric or long-  
term therapy)

**ORAL SUSPENSION**

(orange-flavored)  
125 mg. per tsp. (5 cc.)  
2 oz. bottle

**NEW! PEDIATRIC DROPS**

(orange-flavored) 5 mg. per  
drop, calibrated dropper,  
10 cc. bottle

## COSA-TETRASTATIN\*

glucosamine-potentiated tetracycline with nystatin  
Antibacterial plus added protection against  
monilial super-infection

**CAPSULES** (black and pink) 250 mg. Cosa-Tetra-  
cyn (with 250,000 u. nystatin)

**ORAL SUSPENSION** 125 mg. per tsp. (5 cc.)  
Cosa-Tetracycyn (with 125,000 u. nystatin), 2 oz.  
bottle

## COSA-TETRACYDIN\*

glucosamine-potentiated tetracycline-analgesic-  
antihistamine compound

For relief of symptoms and malaise of the  
common cold and prevention of secondary  
complications

**CAPSULES** (black and orange)—each capsule con-  
tains: Cosa-Tetracycyn 125 mg.; phenacetin 120 mg.;  
caffeine 30 mg.; salicylamide 150 mg.; buclizine  
HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, H.; Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia, Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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**PFIZER LABORATORIES** Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York

OTITIS  
MEDIA  
or  
FRACTURED  
TIBIA?

ACCELERATE THE  
RECOVERY  
PROCESS WITH

**VARIDASE\* BUCCAL**  
TABLETS

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STREPTOKINASE-STREPTODORNASE LEDERLE  
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about  
46 CALORIES  
per 18 gram slice

**Hollywood®  
BREAD**



**INGREDIENTS**

WHEAT, WHOLE WHEAT AND FLAKED OR  
ROLLED WHEAT FLOURS, YEAST, MOLASSES,  
SALT, HONEY, MALT, CARAMEL, SESAME SEED,  
YEAST FOOD, WITH AN ADDITION OF WHOLE  
RYE, OATMEAL, SOYA, GLUTEN AND BARLEY  
FLOURS, PLUS DEHYDRATED VEGETABLE FLOURS,  
INCLUDING CARROT, SPINACH, KELP, LETTUCE,  
PUMPKIN, CABBAGE, CELERY AND PARSLEY.  
CALCIUM PROPIONATE ADDED TO  
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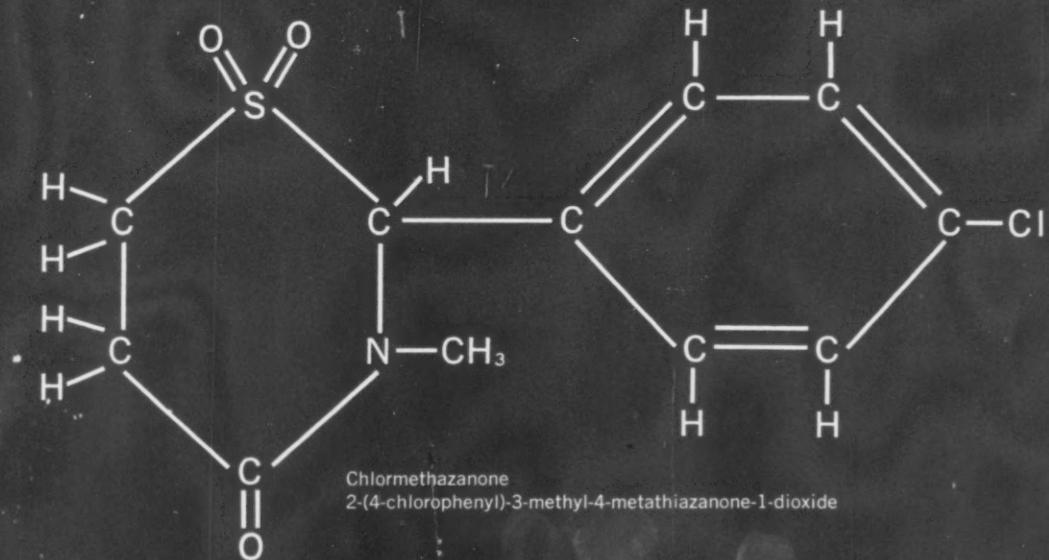
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*designed to be equally effective as both*  
*a MUSCLE RELAXANT*  
*a TRANQUILIZER*

# Trancopal

*the first true "TRANQUILAXANT"\*\**

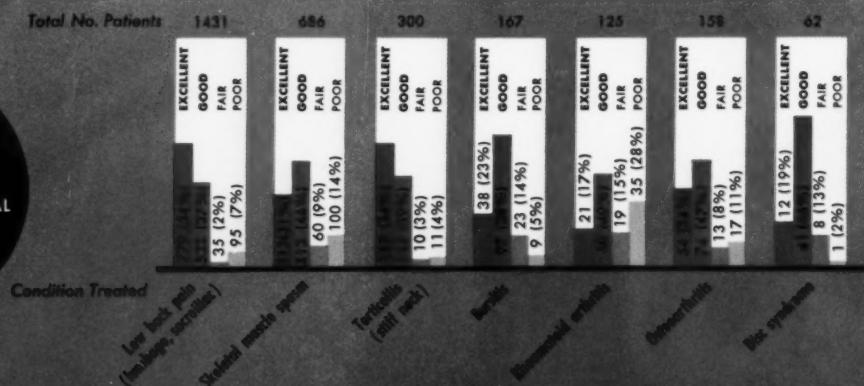
*offering new freedom for your patients...from muscle spasm,  
 from tension and anxiety, from side effects*

\*tran-qui-lax-ant (tran'kwi-lak'sant)  
 [*< L. tranquillus, quiet; L. laxare, to loosen, as the muscles*]

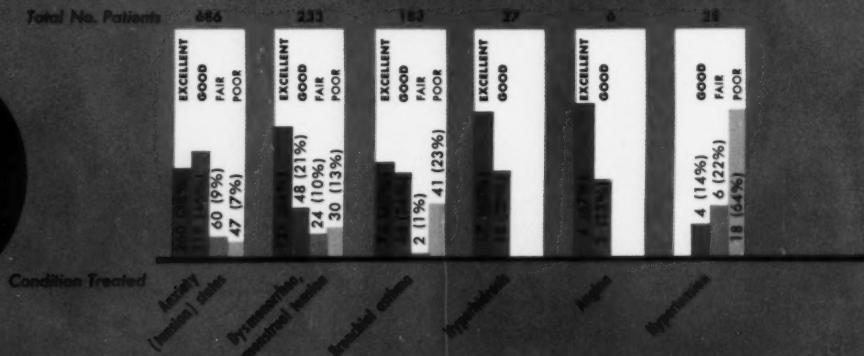
#### EXCEEDS OLDER DRUGS UP TO 4 TIMES IN PERCENTAGE OF CLINICAL EFFICACY (Lichtman)

The results of clinical studies of over 4000 patients by 105 physicians demonstrate that TRANCOPAL often is effective when other drugs have failed. From these studies it is clear that TRANCOPAL probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other chemotherapeutic agent in current use.

#### TRANCOPAL IN MUSCULOSKELETAL DISORDERS



#### TRANCOPAL IN PSYCHOGENIC DISORDERS



## TRANCOPAL... the first true "tranquilaxant"

Both a muscle relaxant and a calmative agent.

In musculoskeletal disorders, 91 per cent effective.

In anxiety and tension states, 93 per cent effective.

Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.

No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.

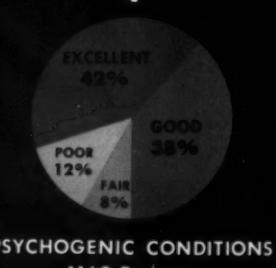
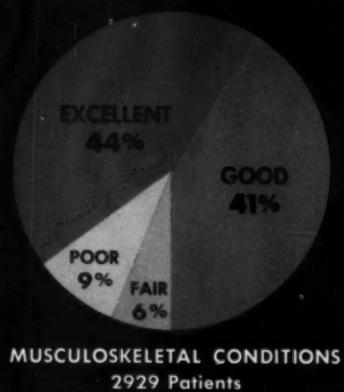
Low toxicity. In animals, even less toxic than aspirin.

No gastric irritation. Can be taken before meals.

No clouding of consciousness, no euphoria or depression.

No perceptible soporific effect, even in high dosage.

### CLINICAL RESULTS IN 4092 PATIENTS.



MAJOR IMPROVEMENT  
84%

## Compare Trancopal with 3 widely used central relaxants

### FOR ACTIVITY

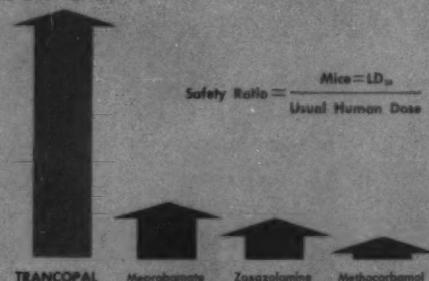
Single Dose

TRANCOPAL	100 mg.
Meprobamate	400 mg.
Zoxazolamine	500 mg.
Methocarbamol	1000 mg.

Daily Dose  
Same as above, t.i.d.

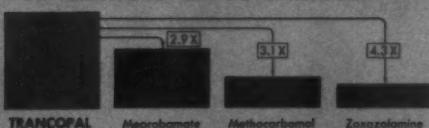
Considering the usual human dose, Trancopal, the first true "tranquilaxant," is four to ten times as potent per milligram.

### FOR SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the  $\text{LD}_{50}$  in mice/usual human dose.

### FOR CLINICAL EFFECTIVENESS



A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of 40 patients received all four drugs in random rotation for several days. While each of the four drugs gave some relief, only the one providing the most effective relief was recorded.

#### INDICATIONS

<b>Musculoskeletal</b>	Psychogenic
Low back pain (lumbago)	Anxiety and tension states
Neck pain (torticollis)	Dysmenorrhea
Bursitis	Premenstrual tension
Rheumatoid arthritis	Asthma
Osteoarthritis	Emphysema
Disc syndrome	Angina
Fibrositis	
Joint disorders (ankle sprain, tennis elbow, etc.)	<b>Neurologic</b>
Myositis	Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis
Postoperative myalgias	

## TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated. . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations." (Lichtman)

# Trancopal

*the first true "TRANQUILAXANT"*

**Dosage:** One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

**Supplied:** Trancopal Caplets® (scored) 100 mg., bottles of 100.

**Winthrop** Laboratories • New York 18, N. Y.

\* Baker, A. B.: *Modern Med.*, 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperative Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Coulston, F.: *Toxicol. & Appl. Pharmacol.* To be published. • Gesler, R. M., and Surrey, A. R.: *J. Pharmacol. & Exper. Therap.*, 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: *J. Pharmacol. & Exper. Therap.*, 122:517, April, 1958. • Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.*, 4:28, Oct., 1958. • Surrey, A. R.; Webb, W. G., and Gesler, R. M.: *J. Am. Chem. Soc.*, 80:3469, July 5, 1958.

1 Ladiez and gentlemen:  
learn all about new VITERRA PEDIATRIC,  
a good supplement  
in a great new package.



5 On your right,  
see Flo-pack's tight  
seal. No risk of  
contamination.

2 First,  
see what happens when  
you push the metered plunger.



3 Aha!  
An exact 0.6 cc.  
comes out this spout.  
Never more, never less.

4 And notice —  
no drip, no waste,  
no sticky bottle.

#### VITERRA® PEDIATRIC

each 0.6 cc. contains:

	M	D	R†	Infants	Children
A (synthetic)	5000 U.S.P. Units	333%	167%		
D (Calciferol)	1000 U.S.P. Units	250%	250%		
B <sub>1</sub> (Thiamine)	1 mg.	400%	133%		
B <sub>2</sub> (Riboflavin)	1 mg.	167%	110%		
B <sub>6</sub> (Pyridoxine)	1 mg.	††	††		
B <sub>12</sub> (Cyanocobalamin)	1 mcg.	††	††		
C (Ascorbic Acid)	50 mg.	500%	250%		
Niacinamide	10 mg.	200%	133%		
Panthenol	2 mg.				

In a d-sorbitol base for better vitamin B<sub>12</sub> absorption  
†Minimum daily requirement has not been established.

DOSAGE: 0.6 cc. or as directed by physician.  
In 50 cc. bottles

no refrigeration needed



NAAD

7 That means  
no hot-weather  
loss of potency.



6 Let's take a minute  
to admire the formula.



8 Now for a farewell treat, a  
taste of delicious, orange-y  
VITERRA PEDIATRIC. How will  
you have it — in fruit juice?  
On cereal? Straight from the  
spoon?

## VITERRA® PEDIATRIC



Special note to doctors who took this tour:

Problems of over- and under-dosage, spillage, spoilage or leakage disappear with VITERRA PEDIATRIC's new metered Flo-pack. Why not consider these advantages when you recommend a vitamin supplement?



NEW YORK 17, N.Y.

SCIENCE FOR  
Division, Chas. Pfizer & Co., Inc. THE WORLD'S  
WELL-BEING

For Real Pain...give real relief:

# A.P.C. WITH Demerol® tablets

Each tablet contains:

Aspirin	200 mg. (3 grains)
Phenacetin	150 mg. (2½ grains)
Caffeine	30 mg. (½ grain)
Demerol hydrochloride	30 mg. (½ grain)

Average Dose:

1 or 2 tablets.

Narcotic blank required.

## Potentiated Pain Relief

WINTHROP LABORATORIES

New York 18, N. Y. • Windsor, Ont.

Demerol (brand of meperidine),  
trademark reg. U.S. Pat. Off.



Of course,

women like "Premarin"

Therapy for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

Doctors, too, like "Premarin," because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen.

**"PREMARIN"®**  
conjugated estrogens (equine)

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Ayerst Laboratories • New York 16, New York • Montreal, Canada

# ACHROCIDIN®

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

*A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.*

**CHECKS SYMPTOMS:** Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

*Available on prescription only.*

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

**TABLETS (sugar coated)**

*Each Tablet contains:*

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

*Bottles of 24 and 100.*

**SYRUP (lemon-lime flavored)**

*Each teaspoonful (5 cc.) contains:*

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

*Bottle of 4 oz.*

- adenitis
- sinusitis
- otitis
- bronchitis
- pneumonitis

*prevents the . . . multifarious sequelae*



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

*in cases of tension*

**Serpate®**  
(Reserpine, Vale)

... the preferred drug where anxiety or emotional agitation must be controlled

... provides sedation without hypnosis, a sense of relaxed well being and tranquility

... effects a gradual and sustained lowering of elevated blood pressure in patients with mild, labile or essential hypertension

supplied: 0.1 mg. and 0.25 mg. tablets in bottles of 100, 500 and 1000, or on prescription at leading pharmacies

*RAUWOLFIA SERPENTINA*

*in cases of hypertension*

**Rauval®**  
(Rauwolfia Serpentina, Vale)

... double assayed to insure optimal therapeutic effect  
tested chemically to insure total alkaloid content  
tested biologically to insure uniform hypotensive action

... ideal therapy in labile and moderate hypertension or as adjunctive therapy in severe hypertension

... achieves gradual lowering of the blood pressure, gentle sedation, tranquilization with prolonged effect even after cessation of therapy

supplied: 50 mg. and 100 mg. tablets in bottles of 100 and 1000, or on prescription at leading pharmacies

 THE VALE CHEMICAL COMPANY, INC. allentown, pa.  
PHARMACEUTICALS

in all  
diarrheas

# CREMOMYCIN®

SUCCINYL SULFATHIAZOLE-NEOMYCIN SUSPENSION WITH PECTIN & KAOLIN



regardless of  
etiology



MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

CREMOMYCIN is a trademark of Merck & Co., Inc.

# Now-All cold symptoms can be controlled

*This new timed-release tablet provides:*

- ...the superior decongestant and antihistaminic action of Triaminic
- ...non-narcotic cough control as effective as with codeine, but without codeine's drawbacks
- ...an expectorant to help the patient expel thickened mucus
- ...the specific antipyretic and analgesic effect of well-tolerated APAP
- ...the prompt and prolonged activity of timed-release medication

**Each Tussagesic Tablet contains:**

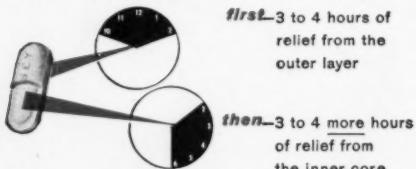
TRIAMINIC® . . . . .	50 mg.
(phenylpropanolamine HCl . . . . .	25 mg.;
pheniramine maleate . . . . .	12.5 mg.;
pyrilamine maleate . . . . .	12.5 mg.)
Dormethan	
(brand of dextromethorphan HBr) . . .	30 mg.
Terpin hydrate . . . . .	180 mg.
APAP (N-acetyl-p-aminophenol) . . . . .	325 mg.

**Also available:**  
for those who prefer liquid medication—

**Tussagesic suspension**

In each 5 ml.: Triaminic, 25 mg.; Dormethan, 15 mg.; terpin hydrate, 90 mg.; APAP, 120 mg.

**Tussagesic timed-release tablets provide relief in minutes, which lasts for hours**



**Dosage:** 1 tablet in the morning, mid-afternoon, and evening, if needed. Should be swallowed whole to preserve the timed-release action.

**Suspension:** Adults—1-2 tsp. every 3-4 hours; Children 6-12 years old—1 tsp. every 3-4 hours; Children under 6—dosage in proportion.

## NEW Tussagesic\*

\*Contains TRIAMINIC to **STOP** running noses  and open stuffed noses orally



Many such  
hypertensives have  
been on *Rauwiloid*  
for 3 years  
and more\*

for Rauwiloid IS better tolerated...  
"alseroxylon [Rauwiloid] is an anti-  
hypertensive agent of equal ther-  
apeutic efficacy to reserpine in the  
treatment of hypertension but with  
significantly less toxicity."

\*Ford, R.V., and Moyer, J.H.: Rau-  
wolfa Toxicity in the Treatment of  
Hypertension, Postgrad. Med. 23:41  
(Jan.) 1958.

For gratifying Rauwolfia response

# Rauwiloid®

ALSEROXYLON, 2 MG.

virtually free from side actions

Enhances safety when more potent drugs  
are needed.

**Rauwiloid® + Veriloid®**  
alseroxylon 1 mg. and alkavervir 3 mg.  
for moderate to severe hypertension.  
Initial dose, 1 tablet t.i.d., p.c.

**Rauwiloid® + Hexamethonium**  
alseroxylon 1 mg. and hexamethonium chloride  
dihydrate 250 mg.  
in severe, otherwise intractable hyper-  
tension. Initial dose,  $\frac{1}{2}$  tablet q.i.d.  
Both combinations in convenient  
single-tablet form.

just two tablets  
at bedtime

After full effect  
one tablet suffices

—



NORTHRIDGE,  
CALIFORNIA

# Compazine\*



*nausea and vomiting  
—from virtually any cause*

- in pregnancy—pre- and postoperative states—gastroenteritis—alcoholism—cancer and chronic diseases
- control is achieved with low dosage—usually 15 to 20 mg. daily—and often within a half hour after the first oral dose

'Compazine' is remarkable for its freedom from drowsiness. Patients carry on normal activities and often experience an actual alerting effect.

*...for immediate control of severe vomiting:*

*Ampuls, 2 cc. (5 mg./cc.)*

*NEW: Multiple dose vials,  
10 cc. (5 mg./cc.)*



*—always carry one in your bag*

*Also available:*

*Tablets, 5, 10 and 25 mg., in bottles of 50 and 500.*

*Spansule† capsules, 10, 15 and 30 mg., in bottles of 30 and 250.*

*Suppositories, 5 and 25 mg., in boxes of 6.*

*Syrup, 5 mg./teaspoonful (5 cc.), in 4 fl. oz. lightproof bottles.*

*Smith Kline & French Laboratories, Philadelphia*

\*T.M. Reg. U.S. Pat. Off. for prochlorperazine, S.K.F.

†T.M. Reg. U.S. Pat. Off. for sustained release capsules, S.K.F.